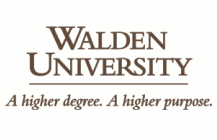

2019

Psychological Characteristics of Sex Offenders

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2019

Abstract

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by

Patrick E. McMunn

MS, Walden University, 2009

BS, Wayland Baptist University, 2004

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology Program

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May 2019

Abstract

Current therapeutic treatment methods are ineffective in identifying at-risk sex offenders and reducing recidivism of known offenders, likely due to inadequate identification of specific traits of sex offenders. Previous research and prominent theories in the area of sex offender treatment, in terms of the biological foundation of substance abuse, behaviors of sex offenders, and the presence of aggression, helped to guide this research. Data about sex offenders were collected, as reported by mental health professionals who treat them and focused on three characteristics: maladaptive interpersonal behaviors, impulsivity, and antisocial behaviors, on which the research questions were formed to detect commonality. For this study, a phenomenological approach was chosen through a qualitative design and an 11-item open-ended questionnaire was developed with which 11 mental health professionals who treated sex offenders were interviewed. The audio was transcribed, the text was coded into the themes of the research questions, and the data was analyzed for commonality. The results indicate that all three traits in the research questions are common among sex offenders. The results of this research added to the framework of understanding of common behaviors among sex offenders and to positive social change by providing a clearer understanding of the three targeted behaviors. The information gathered from this qualitative research will guide larger-scale quantitative studies on the sex offender population, ultimately assisting sex offender treatment providers and forensic interviewers with more rapid identification of traits specific to sex offenders.

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Dedication

I would like to dedicate this dissertation to my wonderful children, Zacharie, Autumn, Liam and Jay, along with my brilliant wife, Devon, for whose ongoing patience and support throughout my academic career have gone unmatched. When my schedule has proven to be stressed or when I felt down on motivation, they were there to pick me up for that extra boost of resolve. Without them, I surely would not have made it this far in my studies.

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Table of Contents

List of Tables

Chapter 1: Introduction to the Study

Introduction

In this chapter, I identify the problem in terms of known characteristics of sex offenders, influences of local law and society affecting treatment programs, and definitions of common terminology. I also discuss historical attempts to use evaluative tools to find commonalities between psychosocial dysfunctions, such as maladaptive interpersonal behaviors, impulsive lifestyle, and antisocial personality behaviors commonly present among of sex offenders. I also offer arguments about the importance of change within the mental health sphere to not only treat victims but find effective methods of treatment to prevent would-be offenders from victimizing others and known offenders from recidivism. I discuss the importance of this research and the positive impact it may have on social change by explaining recent models of sex offenders and the burdens of sexual assault and the negative psychological and financial impact it has on society.

In this study, I used a phenomenological qualitative design to examine reported experiences of mental health professionals regarding the assessment and treatment of maladaptive interpersonal behaviors, impulsive lifestyle, antisocial personality behaviors, and perceived commonality among these factors in known sex offenders. Past researchers using other assessment tools found particular psychological behaviors to be common among many sex offenders in regard to callously and impulsively acting out aggression (Gollwitzer et al., 2007). The Hare Psychopathy Checklist – Revised (PCL-R) has been used by forensic researchers in presentencing competency evaluations to detect common psychological behaviors of sex offenders to determine potential for recidivism

(Boccaccini et al, 2012). Murrie et al. (2012) stated that the PCL-R was useful in identifying areas of marked deficiencies in interpersonal skills, impulsivity, and antisocial behaviors. Therefore, I examined those three deficiencies in this research. It is important to be able to detect and better understand these behaviors because recidivism continues to be a concern for the public when sex offenders are released from prisons or other institutions (Bonta, Law & Hanson, 1998). It is also important to identify sex offender behaviors prior to the commission of an offense. Detecting these behaviors early on would enable the individual to receive treatment, with the possibility of altering behaviors, avoiding the commission of an offense and incarceration, and ultimately reducing the number of victims and decreasing the amount of money the government spends (Donato & Shanahan, 2001).

During the past decade, the U.S. justice system has dedicated a great deal of attention and resources to investigating and prosecuting those alleged to have committed sexual offenses. Media coverage now alerts the public almost immediately when a child or young adult is reported missing. Primetime television currently conducts sting operations to catch potential sex offenders in the act of illicit sexual behaviors (Gaeta, 2010).

Background

Significant research has been conducted in the field of psychology that indicates there are prevalent factors and behaviors congruent with sexual assault (Erickson, Luxenberg, Walbek and Seely, 1987). Erickson et al. (1987) examined a difference between two-point MMPI code types obtained from sex offenders and normal populations. Research had shown that sex offenders tend to exhibit self-gratifying

addictive behaviors, predominantly with the presence of alcoholism (Erickson et al., 1987). They also observed a 2-point peak code among child molester profiles that indicated a tendency for passive-dependency upon others, feelings of discomfort in social interactions, and impulsive behaviors. Erickson et al. (1987) were able to further describe MMPI profile differences between extrafamilial and intrafamilial offenders. For example, extrafamilial offenders almost exclusively scored either a depressive and psychopathic deviate personality, or MMPI-2 profile 4-2/2-4 or a psychopathic deviate and schizophrenic personality, or MMPI-2 profile 4-8/8-4 profile when compared to the average population. Conversely, offenders against adult women were likely to have a psychopathic deviate and hypomanic personality, or MMPI-2 profile 4-9/9-4 profile, uggesting a profile normally found associated with antisocial personality disorder (Erickson et al., 1987).

Sexual offenses and deviancies have become significantly more publicized in the media and consequently are a greater concern for the public. The first problem that society is faced with is detecting sexual offenders and recidivists. If behaviors and personalities indicate individuals who may have violent sexual tendencies but do not act on them, then society can identify and treat these individuals before they engage in illegal activities. Lisak and Roth (1990) estimated that only 10% of sex offenders are detected. Detection of such criminal behaviors may result in incarceration of the offender (Bonta et al., 1998). The second problem that society is faced with is treating sex offenders and potential reoffenders. Several methods of therapy are used to treat sexual deviance and offenses, most of which were built from the framework of relapse prevention models used to treat addiction. However, such models of treatment have proven to be ineffective

for preventing relapse because the process incorporates the philosophy of "three steps forward, two steps back" (Polaschek, 2003). A successful treatment model should incorporate a no-fail model, as any degree of relapse would be considered a violation of parole or statutory laws (Furby, Weinrott, & Blackshaw, 1989).

I used a phenomenological qualitative design to examine reported experiences of mental health professionals who have provided treatment to sex offenders. I selected mental health professionals because they are in the unique position to be able to interact with multiple offenders across various age ranges, ethnicities, and backgrounds. While it would likely be useful to examine many behaviors using open-ended questions, my goal was to examine maladaptive interpersonal behaviors, impulsive lifestyle, antisocial personality behaviors, and perceived commonality among these factors in known sex offenders. I used open-ended questions based on items from the following psychometric measures, respectively: the Interpersonal Closeness Measure (Berger, J., Heinrichs, M., von Dawans, B., Way, B.M., & Chen, F.S., 2016), the Impulsivity Measure (Chan, Lo, Zhong, & Chui, 2015), and the Disturbing Behaviors Checklist II (Algozzine, 2011).

Most identified offenses occur after the sex offender was incarcerated for similar crimes (Polaschek, 2003). A high rate of recidivism is often a good indication that treatment programs are ineffective. Previous research was aimed at smaller numbers of a sex offenders' psychological or biological traits (Polaschek, 2003). Many of the studies conflict with others and, as a result, no systematically effective processes were developed for detection or treatment of sex offenses (Murrie et al., 2012). Using available psychological assessment tools, such as the Interpersonal Closeness Measure, the

Impulsivity Measure, and the Disturbing Behaviors Checklist II, assists in identifying common behaviors shared by the population.

Statement of the Problem

Current therapeutic treatment methods have been ineffective in identifying at-risk offenders and reducing recidivism of known offenders, likely due to inadequate identification of specific traits of sex offenders (Furby et al., 1989). Ethical considerations are also factors because therapists who may be able to identify at-risk sex offenders are usually bound by confidentiality, unless they have real concerns for the safety of their client or potential victims. The assumption by the psychological community has been that an umbrella treatment program that addresses addiction, criminal behaviors, and antisocial tendencies are adequate for mental health professionals to treat sex offenders, not accounting for variances in the type of crime committed. Current treatments also tend to focus on reducing addiction, using treatment models based on substance and alcohol abuse (Polaschek, 2003). Such models are flawed, because they allow for relapse, which is unacceptable for the sex offender population. In order to bridge the gap in research, I used a phenomenological approach to examine mental health professionals' clinical observations to delineate assumptions of what sex offenders present as traits.

I conducted this research by interviewing mental health professionals who specialize in the treatment of sex offenders and examining reported experiences in regard to the assessment and treatment of maladaptive interpersonal behaviors, impulsive lifestyle, antisocial personality behaviors, and perceived commonality among these factors in known sex offenders. The information gathered from this qualitative research

may guide larger scale correlational and experimental studies on the sex offender population. The implications of this research could potentially aid mental health professionals and psychological researchers to develop therapeutic treatment models and methods of early detection of at-risk offenders and potential recidivism. Such information may also be used to target certain manifestations of psychopathy among sex offenders that cause inappropriate and illegal behaviors, ultimately reducing the chances for lapse or relapse of sexual offenses through early detection and intervention programs.

When considering legal ramifications and treatment of sex offenders, the justice system takes a reactive approach rather than a proactive one. With such a large number of recidivism sex offenses, there exists a great deal of pressure to mandate the identification and treatment of sex offenders. The law only provides so much legal jurisdiction when considering sexual offense cases. For example, it is unlawful to mandate treatment beyond a sentence or probation, even when continued therapy may offer monitoring of progress or indicate potential to relapse (Berlin, 2003). Law makers and members of the justice system also aim for increasing sentences so further therapy and monitoring can be accomplished, which raises some ethical concerns.

Findings from this research could contribute to future legislation by providing information that could inform decision makers about appropriate sentences to allow adequate treatment for convicted sex offenders; something past research has not been successful in providing. Examining maladaptive interpersonal behaviors, impulsivity, and antisocial behaviors of criminal sex offenders has the potential to reveal patterns of behaviors. Furthermore, associating psychological disorders with sex offenders may offer suggestions as to proactive treatment for those with predispositions of disinhibitory

behaviors and assist in reducing the likelihood of recidivism across the population of sex offenders.

Purpose of the Present Study

In 2015, it was estimated that the United States spends $151,423 per incident on sex crimes, which is roughly $127 billion a year (NSVRC, 2015). These figures include medical issues, mental health treatment, lost wages, and impact to family systems. Many victims experience life-long mental health disorders, including anxiety, depression, and post-traumatic stress disorder (PTSD) (NSVRC, 2015). Additionally, children who have experienced sexual abuse are likely at-risk for experiencing sexual assault as adults, compounding costs for treatment for the individual. As the costs for victimization of sexual assault may raise concerns, examining the costs for conviction, incarceration, and treatment of the perpetrators should also be noted.

In 2012, according to the U.S. Department of Justice (2015), there were 346,830 reported sexual offenses where a person was sexually violated. The year prior, nearly 166,382 convictions resulted from reported cases of sexual assault (U.S. Department of Justice, 2014), costing millions of dollars in treatment of victims, and lifelong trauma to the victims and their families. Additionally, the cost to build a prison cell is approximately $55,000, while operational costs average $31,000 per inmate, per year (Henrichson & Delaney, 2012). The Center for Sex Offender Management (2000) reports that the average cost to treat a convicted sex offender is approximately $5,000 to $15,000 per year. These figures are derived from reported cases to illustrate the costs of known sex offenses; it should be noted that many more cases go unreported or uninvestigated for many reasons.

In order to be proactive in reducing sexual assault, mental health professionals need to place emphasis on detecting and treating the problem before the sex offender has committed a convictable offense. This research adds to the framework of understanding the existence of common psychological behaviors among sex offenders. I examined reported experiences of mental health professionals regarding the assessment and treatment of maladaptive interpersonal behaviors, impulsive lifestyle, antisocial personality behaviors, and perceived commonality among these factors in known sex offenders. The drive toward better understanding of sex offenders' anatomical and psychological motivations, as well as behaviors may lead to better programs and guidelines to treat known sex offenders and at-risk sex offenders. Detection of certain behaviors may indicate a psychological propensity toward committing sexual offenses. With that in mind, it is important to recognize that a sex offender can be motivated not only by biological and behavioral factors, but antisocial inclinations may also be present, especially in violent sex offenders.

To date, most of the focus among lawmakers and health care institutions has been one of reactive response that is to treat the problem as it occurs. Once an occurrence has been detected, the victim is treated and the perpetrator is possibly incarcerated (Donato & Shanahan, 2001). The problem with the current process is two-fold: first, prison sentences for sex crimes are a temporary fix for society; second, because very little is known about motives and behaviors of sex offenders, it is difficult to discern who has a propensity to commit to criminal acts, whether they are first-time or relapsed offenders. Donato and Shanahan (2001) recognized the importance of effective rehabilitation programs concurrent with and subsequent to a prison sentence. Without adequate

treatment, the sex offender has little chance at rehabilitation. Releasing a possible recidivist back into society has potential to result in additional victims.

Because there are currently no effective methods for detecting, preventing, and treating potential sex offenders, I collected data on known sex offenders, as reported by mental health professionals. The results were based on the grading of three different characteristics: maladaptive interpersonal behaviors, impulsive lifestyle, and antisocial personality behaviors. Understanding the predisposition of a sex offender to exhibit certain behaviors may indicate a propensity to commit a sex offense. Based on the results of the interviews with the mental health professionals, I was able to show through this research how maladaptive interpersonal behaviors, impulsivity, and antisocial behaviors are exhibited by sex offenders.

Research Questions

I chose the qualitative method design for researching behaviors of sex offenders, in terms of maladaptive interpersonal behaviors, impulsivity, and level of antisocial personality, because it analyzes information obtained from interviewing mental health professionals who provide treatment to sex offenders. Additionally, the results that I received from the qualitative design provided more exploratory research than that of a quantitative type of research. Moustakas (1994) explained that researchers who focus on the subjective evidence and study the phenomenology of the raw observations of mental health professionals will assist in understanding of maladaptive interpersonal behaviors, impulsive lifestyle, antisocial personality behaviors, and perceived commonality among these factors in known sex offenders. I chose this design in order to test the research questions:

Research Question 1: How do mental health professionals observe maladaptive interpersonal behaviors in individuals who are known sex offenders?

Research Question 2: How do mental health professionals observe impulsive behaviors in individuals who are known sex offenders?

Research Question 3: How do mental health professionals observe antisocial personality behaviors in individuals who are known sex offenders?

Research Question 4: How do mental health professionals see commonality among the behaviors reported corresponding to RQs 1–3 in individuals who are known sex offenders?

Many tools are useful in detecting levels of present behaviors, however, they fail to accurately identify behaviors. Thus, open-ended questions afford mental health professionals the capability to describe observable behaviors. Hare (1991) used the PCL-R to examine prison populations and a correlation with antisocial personality behaviors because the assessment can be used to gauge the effects of rehabilitation. He reported that among offenders there is increased callousness, selfishness, and remorseless use of others. In addition, he also described findings of increased maladaptive interpersonal tendencies, such as difficulties with affect. Finally, Hare examined and described antisocial behaviors as chronically unstable and antisocial lifestyle, impulsiveness, and risky behaviors (Hare, 1991). Berger, Heinrichs, von Dawans, Way, and Chen (2016) developed the Interpersonal Closeness measure to assess interpersonal relationship difficulties of an individual, from which I used as framework for the interview questions pertaining to maladaptive interpersonal relationship issues among sex offenders. My use of the items measured the participant's perspective on relational values and concepts. The

Impulsivity Measure, developed by Chan, Lo, Zhong, and Chui (2015) developed the Impulsivity Measure to assess the level of impulsivity of incarcerated male offenders. Impulsivity is measured by asking the participant questions about common behaviors, given certain situations. Finally, to measure antisocial personality behaviors, I used questions from the Disturbing Behaviors Checklist II, developed by Algozzine (2011). Similar to the Impulsivity Measure, the Disturbing Behaviors Checklist II uses items that inventory common behaviors and history of behaviors to detect traits that are similar to individuals who have been diagnosed with antisocial personality disorder.

Definition of Terms

Androgens: Sex hormones that are genetically more predominant in men than women. These hormones are thought to be the main reason for developmental differences between male and female genders (Ellis, 1991).

Successive approximation: Method for finding the output of an unknown variable by repeated evaluation of a known behavior (Harsch & Zimmer, 1965).

Explicit aggression: Tendency to act upon anger, fear, or rage as emotions are experienced. Individuals are spontaneous and impulsive. A history of criminal behavior may be an indicator (Gollwitzer et al., 2007).

Externalizing: Acting out anger and aggression as a physical response to experiencing rage and hurt (Krueger et al., 2002).

Implicit aggression: Tendency to not externalize anger, fear, or rage. Instead, attempts to alleviate such emotions occurs through deceit or anonymity. Responses tend to be more latent and covert (Gollwitzer et al., 2007).

Modeling: Learning to behave or act in a specific way by observing the actions of others, particularly through idolization (Ellis, 1991).

Paraphilia: Sexual attraction to and obsession over unusual stimuli. Includes fetishism, voyeurism, and exhibitionism (Blanchard, 1992).

Social learning theory: Theory that states learning occurs from others within a group or community. Includes gender roles, emotions, and values (Ellis, 1991).

Significance of the Study

Lisak and Roth (1990) described the following in their study, which is directly related to this research. They wrote:

> The only source of data on the motives and psychodynamics of rapists has been studies of incarcerated populations. Since it is estimated that fewer than 10% of rapists ever reach the criminal justice system, and even fewer are ultimately incarcerated, there are substantial grounds for questioning whether these data can be generalized to unincarcerated rapists, the men responsible for 90% of rapes. Furthering our understanding of these men and what motivates their behavior would contribute to identifying sub groups more at risk for committing sexual aggression, and to framing interventions for preventing their aggressive acts. Such understanding might also help women to avoid becoming victims of sexual attacks (p. 268).

With the inclusion of pedophiles and child molesters in this research, Lisak and Roth's (1990) conclusion can further justify treatment methods in order to protect of children from victimization. Just as many U.S. communities have established anger management to identify, address, and attempt to mitigate psychological and biological

traits of rage and aggression in an attempt to prevent child or spouse abuse (Hazaleus & Deffenbacher, 1986), programs could be instituted for the detection, prevention, and treatment of persons displaying patterns of behaviors found in sex offenders. The results of this research may reveal indications of potential sex offenders and help clarify common behaviors.

Limitations of the Study

In this research, I used a phenomenological qualitative design to examine reported experiences of mental health professionals regarding the assessment and treatment of maladaptive interpersonal behaviors, impulsive lifestyle, antisocial personality behaviors, and perceived commonality among these factors in known sex offenders. I selected the samples of practitioners from a small geographical area around Williamsport, State College, and Scranton, Pennsylvania representing only those who treat sex offenders within the United States. It should be noted that those incarcerated for sexual crimes are convicted based on federal and state statutes.

To represent the target population in this research, I selected a sample of mental health professionals who treat individuals convicted of a sexually based crime. I selected participants based on their self-reported experience in the treatment of sex offenders. I selected participants for the interview and asked them to describe their perspective of how sex offenders either differ or exhibit similarities in behaviors of maladaptive interpersonal behaviors, impulsive lifestyle, and antisocial behaviors.

Antisocial tendencies, as reported by those who specialize in the treatment of sex offenders, may have been present because the offender had acted against legal boundaries. Impulsivity was likely a major contributor for sex offenders, along with the

drive toward gratification, leading to being caught. It is conceivable that those who have tendencies similar to those of sex offenders' have an element of self-control, at least enough to not be detected by the legal or health systems (Ellis, 1991). Further research will need to be considered to examine how perpetrators exercise control over urges.

Another concern about the design of this research was the unintended inclusion of pedophiles in the sex offenders' classification. The term itself is inclusive of those who have been caught trafficking, producing, or merely possessing illicit child pornography (Seto, Cantor, & Blanchard, 2006). Statutory regulations vary from state to state as to the specific content of the photography and its legality, so it is difficult to fully define the term. The main reason for their inclusion was the popular theory that pornography is the gateway to sex offenses (Seto et al., 2006). Studies have shown a strong correlation between known sex offenders and obsession with pornographic materials (Linz, Donnerstein, & Penrod, 1988). Due to the sensitivity of the population, it could be expected that any surveyed data contained 'socially appropriate' answers, yielding a lesser problem than that which really exists. I included in the design of this research measures in order to address the tendency of participants to fake good on self-reports, by increasing a sense of anonymity of the participants, providing their responses do not indicate previously unreported or ongoing criminal activity. As a measure of safety, I informed participants of my obligation to report criminal activity.

The use of open-ended questions is necessary in detecting unedited and unformatted commonalities in the participants' responses to the interview questions. While I selected a qualitative design for this research, it should be noted that there are some limitations to qualitative over quantitative designs. As Atieno (2009) described,

subjectivity may lead to procedural problems, due to participants being permitted to respond to each question without any limits to words, time, or tone. Even though I selected to ask the interview questions in a particular order, the participant was not bound by any procedure or guidance in how she or he responded. Another limitation to this study is exact replication of responses due to variability in participants' answers to open-ended questions. Unlike the objectivity of quantitative research designs, qualitative research designs are subjective, thus it would be difficult to get the exact same or similar responses from other participants (Atieno, 2009). In this study, I examined qualitative data between unedited and unprompted responses from 11 mental health professionals. As such, it is also important to note some threats to external validity with a qualitative design as the sample size is significantly smaller in size, when compared to a quantitative design. This lower number examined a snapshot of the population in order to assist with future directions of quantitative research of common behaviors of sex offenders.

Summary

In the following chapters of this paper, I explain the procedure for collection and analysis of data through the use of open-ended interview questions in attempt to test the research questions. The goal of the literature review is to determine how previously documented theories and research have either succeeded or failed. I incorporated some theories into this study to provide a starting point for this research.

Chapter 2: Literature Review

Introduction

The purpose of this chapter is to provide context for the study with a background and an understanding of the burdens of sexual assault, and the negative psychological and financial impact it has on society. In this chapter, I have included previous research and prominent theories in the area of sex offender treatment, in terms of biological foundation of substance abuse, behaviors of sex offenders, and the presence of aggression. Polashek (2003) observed a correlation between sex offenders and substance abuse. Nearly all perpetrators of sex offenses experienced higher than average use of alcohol, narcotics, or illegal prescriptions. Ellis (1991) suggested that sex offenders are biologically different than the rest of the population.

According to Ellis's (1991) synthesized theory of rape, hormonal imbalances are a likely contributor to innate motivation to commit rape. Krueger et al. (2002) supported Ellis's theory using the Minnesota Twin Family Study (MTFS). They found that certain behaviors of sex offenders within Ellis's theory such as aggressiveness, antisocial behaviors, addictive behaviors, and even personality types appear to be hereditary. Berlin (2003) discovered a higher level of aggression among sex offenders when compared to control groups. For the purpose of this study, I included theories from previous studies to form new hypotheses in an attempt to formulate a more accurate and better-defined set of behaviors. Edens, Hart, Johnson, Johnson, and Oliver (2000) asserted that the use of open-ended questions in research has the advantage of strengthening prior research. As such, I used open-ended questions to not only to describe psychological traits in terms of

antisocial behaviors, but also to potentially strengthen prior research of treatment of sex offenders.

Literature Search Strategy

The information gathered from this qualitative research may guide and encourage larger scale correlational and experimental studies on the population of sex offenders. In order to capture accurate information about characteristics affiliated with sex offenders, it is crucial to fully understand biological and psychological factors that are common among sex offenders. I chose to establish the framework of this research using theories of sex offenses, antisocial behaviors, and sexual deviancy. For the purposes of this research, I identified the bulk of my sources through EBSCO Research database system, primarily PsycARTICLES and PsycINFO, as well as using local library and internet searches.

Neuropsychological Model

Currently, there are several theories that are used to attempt to explain the psychological and biological drives of sex offenders, in particular, offenders demonstrating antisocial behaviors (Kandel & Freed, 1989). This in part has led to the development of numerous treatments and therapies to aid in the rehabilitation of offenders, such as court-ordered sex-drive reducing drugs (Miller, 1998). While drug therapy may be a short-term fix for mitigating the biological factors that drive the offender to offend, it is only effective if the individual is taking the prescribed drugs. Once the court order has expired, treatment compliance becomes a serious concern, potentially leading to recidivism (Miller, 1998). There has been little empirical evidence found that explains the motivations of sex offenders. Theories of how sex offenders

function range from instinctive biological drives to cognitive learning, as explained by both Ellis (1991) and Hanson and Morton-Bourgon (2005).

Polasheck's (2003) research revealed that sex offenders demonstrated similar motivational characteristics as those seen in various addictions and impulsive behaviors. In his research, the need for immediate gratification became the motivating factor behind engaging in illegal or questionable behavior. Relapse prevention programs based on such theories targeted the tendency for self-gratification by instilling a sense of authority and social order similar to Alcoholics Anonymous. A major problem with the treatment of sex offenders is that no effective intervention exists, partly because unlike substance abuse, cessation had most likely occurred once the offense had been detected (Polaschek, 2003). Only then is the offender potentially incarcerated and identified in the community. In contrast, substance abusers may relapse with little or no legal or social consequences. Relapse for sex offenders is prohibited, whereas relapse for substance abuse is expected and often forgiven.

Thought patterns for those demonstrating antisocial behavior have been shown to be directly connected with frontal lobe functioning (Kandel, 1989). A person demonstrating such behaviors is prone to making hasty and apathetic decisions that could harm others in pursuit of self-serving goals and personal gratification. Kandel (1989) also demonstrated that dysfunctional frontal lobes hinder one's ability to make conscientious decisions, thus resulting in antisocial ideologies. Kandel (1989) conducted research on 124 participants demonstrating violent behaviors. Of the 124 sampled, 37 were diagnosed with neurological dysfunction. Although this was only 30%, Through his research, he helped modern psychology understand that biological factors may contribute to

psychological disorders and ultimately, committing violent crimes and lacking empathy to experience remorse for their actions.

Cognitive-Behavioral Models

In order to better understand why sexual offenders commit criminal acts, I based this research upon three main principles: understanding behavioral and cognitive factors of sex offenders, theories of antisocial behaviors, and addiction. I selected behavioral and cognitive factors for their content on learned aggression and violence. Additionally, I chose modern cognitive-behavioral models to demonstrate that some behaviors and actions occur due to past experience of similar actions, similar to Greenwald, McGhee, and Schwartz's (1998) research on measuring differences in implicit cognition. Antisocial models are important to understand, because apathy toward others yields a lack of remorse for committing self-fulfilling acts (Kandel & Freed, 1989). Theories of addiction should be equally understood because of the compulsive nature of the sex offenders' behaviors (Krueger et al., 2002). Even though laws and ethics are present, inhibitions are disregarded when the offender pursues gratification, which has been associated with addictive behaviors (Krueger et al., 2002).

In this research, I used cognitive-behavioral models to explain the behavior components of interrelationship, impulsivity, and antisocial behaviors. Specifically, I used questions that examined the participants' understanding of the sex offenders' behaviors and the sex offenders' perceptions of what they have done and the impact they had on the lives of others, which were crucial to this research.

Behaviors of Antisocial Personality and Addiction

What separates sex offenses from other addictions are the resulting effects of recidivism. When a chemically-dependent addict relapses, incarceration is not always the consequence. Addictive behaviors will primarily affect the addicts themselves. Sex offenders, in contrast, cause long term emotional and physical harm to others (Chaplin, Rice, & Harris, 1995). By definition, a lack of empathy or remorse by those who cause harm to others is antisocial (Hanson & Morton-Bourgon, 2005). A mix of antisocial characteristics and deviant sexual preferences, according to Hanson and Morton-Bourgon (2005), results in a higher rate of recidivism. The need to gratify oneself is offset by social and cultural values. The higher the degree to which values are held, the less likely one would be to sexually pursue non-consenting victims especially under relapse conditions (Bonta, Law, and Hanson, 1998). Miller (1998) reported that relapse was twice as likely to occur in sex offenses as it did in many other offenses or addictions. He also demonstrated through his research that programs designed for other violent criminals had very little effect on recidivism of sex offenders.

I did not attempt to examine addiction through this research, but simply the existence of the relationship between addictive behaviors and the commission of sexual offenses. Addiction is a large component of the inability to moderate maladaptive behaviors. Sex offenders who demonstrate addictive behaviors have two disadvantages through their treatment process. First, they may use substances that lowers their inhibitions, and second, they may find it harder to resist sexual temptations and urges.

Psychological Dimensions of Sex Offenders

Through this research, my goal was to identify commonalities between three behaviors among sex offenders: maladaptive interpersonal behaviors, impulsive behaviors, and antisocial personality behaviors. To better understand the behaviors examined in this study, I used the following dimensions and backgrounds to lay framework for this research.

Dimension 1: Maladaptive interpersonal behavior

Erickson, Luxenberg, Walbek, and Seely (1987) conducted testing using the original Minnesota Multiphasic Personality Inventory (MMPI) and detected anger leading to marital or familial discord to be present among sex offenders across all subcategories. However, incestuous offenders were also described as more prevalently externalizing or "acting-out" their aggression through sexual gratification within the family. According to Ellis (1991), aggression is expected to be relatively prevalent across the sex offender sample, and it is conceivable that the sex offender will be likely to become a recidivist if aggression is not treated.

Dimension 2: Impulsivity

The second dimension, impulsivity, was described as high-risk among the previously examined sex offender group, by historically engaging in means of self-gratification. Erickson et al. (1987) reported almost half of their participants were chemically dependent, reducing inhibitions that normally reduce impulsivity. Addictive behaviors, according to this model, are indicative of self-indulgence and disinhibitory actions for the perpetrator. If an individual is predisposed to addiction and other dimensions are present, it is likely that the person will exhibit actions without regard to

consequences (Krueger et al., 2002). Additionally, it can be deduced that substance abuse works favorably for the offenders by helping to loosen inhibitions when attempting to act out sexual desires.

In Krueger et al.'s (2002) research, they examined the addictive behaviors of sex offenders. In many sexual assault cases, the perpetrator uses alcohol and drugs to incapacitate their victims. However, this is would not be considered addictive behaviors in the context of understanding the behaviors of the perpetrators. Drugs and alcohol are used as weapons against victims, not as means of lowering inhibitions.

Dimension 3: Antisocial Personality

Erickson et al.'s (1987) research was very useful in describing psychopathic behaviors. Moreover, through their analysis, Erickson et al. were instrumental in the field of sex offenders to detect various maladjustments, impulsive behaviors and callous coping mechanisms within the individual. According to Erickson et al. (1987), unipolar and bipolar depression were present across the samples, and attachment deficits were comorbid with depression and detected by familial instability within the MMPI. This may be attributed to how the individual perceived familial roles during childhood. Antisocial personality were indicated by how the mental health professional reported behaviors. Based to Erickson et al.'s theories, it was expected that the mental health professionals would report that the sex offenders tended to demonstrate a lower desire to conform to social standards by being truthful and open during their therapeutic sessions.

Through this research, I considered that a history of psychological disorders would likely be recorded, to include previous criminal activity. Hanson and Morton-Bourgon (2005) explained that those who are prone to becoming recidivists will most

likely have an obvious history of similar crimes, showing less response to all rehabilitative treatments or counseling as well as lack of regard for human endangerment or legal consequences. Hare (1991) asserted that the detection of antisocial practices and behaviors can impact the thought processes and empathetic responses of sex offenders. Through this research, I used open-ended questions that focused on detecting more precisely, antisocial predisposition by describing lack of empathy to emotions, similar to Hare's (1991) research using the PCL-R.

The question that seems to dominate research about recidivism, proactive diagnoses, and treatment models is the mental state of sex offenders while committing the crime. Are such behaviors driven by biological influences, cognitive-behavioral factors, or by both? Ellis (1991) postulated that sex offenders have hormonal imbalances particularly with androgens that contribute to higher sexual urges and aggression. Two factors support this theory: a) sex offenders are mostly men, and b) men possess much higher levels of androgens than women. However, higher sex urges are not the single driving factor in sex offenders (Ellis, 1991). Cognitive learning (Greenwald, McGhee, & Schwarz, 1998), exposure to sexually charged stimuli (Kercher & Walker, 1973; Lewis & Johnson, 1989), and predisposition to psychological disorders (Hanson & Morton-Bourgon, 2005) have all been demonstrated as prominent factors in the commission of sexual assault and recidivism.

Experience and Stimuli Contributions

Many other researchers have identified factors that contribute to the commitment of offenses, such as sexual ideological roles, previous positively reinforced sexual behaviors, desensitization by lewd depictions, and substance abuse (Lisak & Roth, 1990).

Seto, Cantor, and Blanchard (2006) described many of these factors as they relate to pornography; pornographic material seems to be the gateway to sexual offenses. Their research showed a strong correlation between the age depicted in pornographic images and the sexual age preference of convicted pedophiles. Similar studies have shown that violent sexual predators have higher reactivity toward pornographic material that depicts violent and socially unacceptable sexual content (Kercher & Walker, 1973). The images usually depict ideological roles such as women in helpless roles and men dominating them. Sexual gratification is achieved through masturbation; hence the rejection by others is not present, and the event becomes a positively reinforced sexual experience. Consequently, the likelihood of viewing more pornography will increase and more exposure to other similar situations is likely to occur (Linz, Donnerstein, & Penrod, 1988). Further desensitization with more violent material had been shown to correlate with an emotional disconnect between the offender and the victim, while a lack of empathy is exhibited for the victim of the sexual offense (Linz et al., 1988).

Symptoms associated with incarcerated sex offenders

Berlin (2003) claimed that there are no current diagnosable conditions for rapists, child molesters, sadists, etc. However, researchers who used the PCL-R and PCL:SV to evaluate sex offenders effectively demonstrated the assessment tools' sensitivity in detecting differences in antisocial tendencies between violent criminals, rapists, and child molesters, as evaluated in presentencing and institutional settings (Brown & Forth, 1997; Murrie, Boccaccini, Caperton, & Rufino, 2012). Detection of psychopathy is a relatively common method for predicting recidivism in sex offenders released from maximum-security prisons. The use of most assessment tools outside presentencing or parole-type

settings could eliminate extraneous factors that could taint the results. An example so an extraneous factor is a convict attempting to give a positive appearance during an evaluation as to gain liberties or freedom back.

During Erickson, Luxemburg, Walbek, and Seely's (1987) research on personality behaviors of sex offenders, they found that 50% of their subjects met the criteria for chemical dependence, indicating a potential for other underlying psychological issues such as depression or other maladjusted coping mechanisms. Sadism, fetishism, and other ideologies congruent with sexual deviance have been described as a type of compulsive sexual behavior (Risen & Althof, 1990). Such behaviors have been treated with antidepressants used to treat compulsive behaviors and anxiety disorders. A majority of subjects who engage in such behavior have been traditionally treated with therapy and drugs designed specifically for obsessive-compulsive behaviors. In order to understand why sex offenders present with maladaptive interpersonal behaviors, impulsivity, and antisocial behaviors, it's important to conceptualize theories that have contributed to explaining the behaviors and motivations of sex offenders.

Synthesized Theory of Rape

Ellis (1991) proposed four possible explanations for biosocial motivations of sex offenders. He attempted through his research to answer the flood of questions from the public during the 1970s and 1980s. Ellis (1991) charged the media with responsibility for its contribution to, what he called, *the social learning theory.* According to Corby, Hodges and Perry (2007), the media perpetuates examples of acceptable social behaviors through modeling processes where the audience is not only desensitized by visual depictions of lewd acts, but would be more likely to imitate violent behaviors pertaining

to their respective gender. This, according to Ellis (1991), holds particularly true with depictions of lewd sexual acts. Coupled with the theory of evolution, that purports men innately seek multiple partners for successful procreation, both theories create a paradigm that favors the male utilizing forceful methods to achieve such goals (Kercher & Walker, 1973; Ellis, 1991; Corby, Hodges, & Perry, 2007).

In the synthesized theory of rape, Ellis (1991) combines innate motivations such as physiological tendencies with learned responses, either through modeling or emotional inadequacies. Ellis' (1991) states in his first proposition of the rape theory that sex drive and the desire to control, act as the motivator for rape. The sex drive, as Ellis explained, are hormonal and unlearned sexual responses that are initiated from the limbic system. Biologists have demonstrated that sexual desires and motivations are brought about by testosterone in men and estrogen in women. Without altering diets and natural chemistry within the body, the levels of functioning are usually created and maintained through biological means, allowing very little, if any, cognitive control over physical reactions. However, the individuals who experience those urges, can suppress their reactions and the final outcome of the sexual behavior is ultimately determined by learned experiences (Ellis, 1991). Sexual desire is not only an innate drive, but nature has demonstrated among various animals that a control drive is also present among men. Ellis (1991) calls this the "drive to possess and control" (p. 631) and is expressed in many species by burying, hoarding, or guarding of proclaimed resources. Actions to maintain control are contrived as violent or manipulative behaviors.

In his first proposition of the synthesized theory of rape, Ellis (1991) considered both the sex drive and the drive to possess and control to coexist and feed into sexual

behaviors. Hence, the motives of rapists are primarily sexual in nature, and less learned. Ellis conceived the first proposition based on six pieces of evidence: a) The assailant demonstrates gratifying sexual desires leading up to the attack. For example, he will usually attempt to buy drinks or use deceitful measures to initiate a sexual relationship. b) Men will use intoxication from either alcohol or drugs as a tool to incapacitate their victims. This measure demonstrates a means of possessing and controlling the victim in order to satisfy the sex drive. c) Little evidence exists that the ultimate goal of the assailant is to merely dominate their victim. For instance, according to self-reports, the rapists most often times use dominance as means of gaining copulatory access. d) A study by Hall (1987) showed that women were twice as likely as men to believe that rape was a drive for power and satisfying rage. With men as the forerunner of committing sexual offenses, Hall (1987) illustrated through her study that men do not believe they suffer from a need to gain power and control over females, much less satisfy internal rage. e) Studies by Craig, Kalichman, and Follingstad (1989) denounced that men who commit rape, experience anymore rage and anger than those men who engage in consensual sex. f) Both genders assigned less blame to the assailant if the victim is dressed provocatively (Lewis & Johnson, 1989).

In the second proposition, Ellis (1991) expounded upon the first by explaining that men's sex drive is notably stronger than a women's due to hormonal differences. The basis of this proposition is also a reiteration of the theory of evolution that posits the men have an innate drive to procreate across multiple sexual partners (Ellis, 1991). According to Ellis (1991), men expend approximately 15 minutes for each session of procreation attempts whereas women are dedicated to more than nine months to conceive, carry, and

bear a child. Sexuality is more of a personal commitment during pregnancy and birthing thus, women are more focused on monogamous relations than their male counterparts (Ellis, 1991). Beyond bearing a child, women show an inherited dedication to rearing the child (Ellis, 1991). Although evolutional theories explain the commitment of sexual partners, it does not fully illustrate men's use of force to gain copulatory access to women. However, Ellis (1991) explained that men are more likely to initiate sex, demonstrate a higher frequency of sexual gratification through masturbation, and show less attachment to women with whom sexual encounters have occurred.

Ellis (1991) indicated that individuals inherit gender roles not only from genetics, but through cultural values as well. Ellis (1991) suggested that such roles are acquired through *learned* processes, and not biological. This idea is the premise for Ellis's (1991) third proposition, "humans are not simply born rapists" (p. 633). In the first two propositions, Ellis (1991) argued that a genetic or evolutionary predisposition to learning rape is based on biological drives. However, the behavioral aspect of sexual gratification is learned. In his synthesized theory of rape, Ellis (1991) posited that sexual behavior may be fueled by sexual drive, but is fundamentally experiential from past successful trials. Arguments have arisen regarding the use of illicit material such as pornography, which Seto et al. (2006) implicated in desensitizing and fueling illicit actions of sex offenders, but Ellis (1991) classified such material as objects of desire and not entry into proneness to rape. According to Ellis (1991), pornography is not the major initiating factor in a sex offender's experience. He did, however, concede that media can implant ideology of gender roles, and for pornography, implant such roles regarding sexual roles and behaviors.

According to Harsch and Zimmer (1965), if a man acquires sex using violence and a positive outcome is achieved for satisfying or suppressing his sexual urges, then the likelihood of replicating such behavior will be significantly increased in an attempt to achieve similar results. Similarly, if the individual uses more force and a more desirable outcome is achieved, then the assailant will be in a curve known as *successive approximation* (Harsch & Zimmer, 1965). This term applies to this study, because each time a sex offender engages in sexual behavior and results in gratification, an output-expectancy occurs for the next instance of sexual intercourse and a learned response has taken shape, similar to what Harsch and Zimmer (1965) found through their research. Based on Harsch and Zimmer's (1965) assertion, I deduced that denial by the women will most likely result in the sex offender's increasing efforts and force to establish a newly learned expectancy.

Ellis (1991), in his first three propositions described the individual using progressive force to gratify sexual desires, usually seen in non-violent date rape. But, Ellis (1991) further described situations when the use of violence without fear of reprisal is present in his fourth proposition. He argued that men are especially sensitive to their own genetic hormonal makeup. That is, those hormones that are particularly sensitive to punishment and consequence counterbalance hormones responsible for sexual desire. For example, the hormones metabolite and estradiol contribute to learning processing by assigning levels of sensitivity to the suffering of others (Ellis, 1991). If such hormones are unbalanced, then the fear of punishment will be lower than normal (Ellis, 1991). When the factor of an imbalance in hormones responsible for consequence awareness, in conjunction with higher levels of testosterone (sex drive and aggression), there can be an

increase in the predisposition toward a violent sex offender's behaviors (Ellis, 1991). Androgens are responsible for the functionality of the brain as well as physical differences between men and women (Ellis, 1991). These chemical levels are thought to vary as early as during the development of a fetus. Based on the genetic makeup, further stages, such as puberty, warrant development and release of androgens into the bodies and minds of men (Ellis, 1991). In Ellis' (1991) first proposition theory, he explained the reasons why aggressive behaviors exist in younger men and early adolescents where little exposure to cultural influences is likely to account for such actions.

In the fourth proposition, Ellis (1991) asserted that androgens are the key elements in how a man responds to sexual desires and how he perceives punishment and consequences, thus hinting varying predispositions across the male gender to committing rape. He suggested that individuals with higher levels of androgens at earlier stages may be more prone to using violence and deceit in order to achieve copulation. Together with lower sensitivity to adverse consequences and remorse, a sex offender may exhibit a more serious problem with antisocial behaviors, such as the use of severe violence or death as a means to gain copulatory access. Ellis (1991) theorized that an increased level of androgens might contribute to behaviors that disregard punishment or even empathetic emotions with the suffering of others. Thiblin and Pärlklo (2002) expounded upon this theory by researching subjects who have altered their androgen levels through the use of steroids. They based their research on five subjects who used anabolic androgenic steroids (AAS) and had no prior history of antisocial behavior. Through the results of their research, Thiblin and Pärlklo (2002) revealed that the use of AAS was strongly

correlated with the onset of antisocial behavior, further strengthening Ellis' (1991) proposition.

Behaviors of Antisocial Personality Theory and Alcohol Addition

Krueger et al. (2002) offered a much more scientific explanation – genetics. In their research, Krueger et al. (2002) used data from the MTFS. They attempted to identify a comorbidity of alcohol dependence, antisocial behavior, and personality across heredity. They not only concluded that antisocial behaviors, personalities, and addictiveness are genetic, but also that they could cross-analyze each disorder to determine the variable in the other twin. Krueger et al. (2002) analyzed monozygotic (MZ) and dizygotic (DZ) twins as well as parents. Through their research, Krueger et al. (2002) also provided crucial information that suggested a systematic pattern may exist, linking diagnosed disorders within the DSM-IV (APA, 2000). Once again, substance dependence and criminal behavior had been detected as comorbid. If genetic predisposition contributes to the etiology of disorders pertaining to addictive behaviors and antisocial personality, then it is conceivable that any subsequent disorders pertaining to behaviors and personality may also be inherited.

Krueger et al. (2002) helped to define antisocial personality behaviors as the externalization of personality disorders. Behaviors would include seeking new stimuli, disinhibition, and impulsive behaviors. Addictive behaviors and antisocial personality have a positive correlation with each of the disorders. For example, an individual who is addicted to alcohol will exhibit a partial or total disregard toward the wellbeing of others by engaging in drunk driving, financial hardship, and abuse. Alcohol is also used as a means to externalize inhibitions that would not normally be acted upon in the absence of

alcohol. Actions of addicts are usually not well thought out and are normally disorganized as a result of the addiction, so impulsivity would be observed.

Krueger et al. (2002) suggested that earlier signs of addictive behaviors and antisocial personality can be detected as young as three years of age. The ability of the individual to cope with stressful situations and restricted impulsivity during such situations may indicate how well the child has adjusted. Later indications in adolescence of such disinhibitory actions may be a sign of criminal behavior during adulthood. Along with Polasheck's (2003) theory of addiction and self-gratification, Krueger and others' (2002) theory is crucial to this research in helping to explain how impulsive behaviors are widely exhibited by sex offenders.

Summary

The general public presumes that sex offenders can be merely dispensed and treated within the judicial system and department of corrections, but caution should be made with such assumptions (Tabachnick, 2013). As Miller (1998) demonstrated, sex offenders still possess civil liberties, and the state and federal governments are very limited in the imposition of treatment for such individuals. Eventually, the offender may serve his or her sentence and be released into the community. With the potential for significantly high recidivism rates among sex offenders, it is extremely vital that a treatment plan is developed, implemented, and followed up on a voluntary basis.

Ellis (1991) provided a plausible theory regarding the targeted biological and psychological systems of sex offenders, but treatment does not become an issue until the problem is detected, ultimately resulting in the incarceration of the offender. Our nation's constitution protects convicted individuals from being 'coerced' into treatment or

mandated continuation of treatment beyond the term of the sentence, thus impeding upon volunteerism. Krueger et al. (2002) reported tendencies of impulsivity and aggression exists within those who exhibit antisocial personality. Such tendencies may present a problem with the sex offender's willingness to comply with social norms and ultimately volunteering to start and complete such treatments.

In this research, I focused on the qualitative analysis of information, which gathered from mental health professionals who specialize in the treatment of known sex offenders in an attempt to develop a systematic pattern to diagnose persons who have either not yet committed illicit behaviors or have not yet been detected. The goal of the psychological community should be to analyze the past behaviors and tendencies of convicted rapists, use the data to help identify would-be offenders, apply intervention and treatment plans for patients or clients, and introduce a systematic program for prevention of recidivism. Such a process would afford the psychological community more access to and confidentiality for those who have not relapsed and reoffended.

Standardized tests already exist for models of maladaptive interpersonal behavior, antisocial behavior, and impulsivity. My aim through this research is to yield an effective method for detecting propensities toward illicit sexual behavior. In Chapter 3, I provide a description of the selected methods for obtaining measures of maladaptive interpersonal behaviors, impulsive lifestyle, and antisocial personality behaviors as reported by mental health professionals who treat sex offenders, and comparing such data to identify commonalities in reported behaviors.

Chapter 3: Method

Introduction

The purpose of this research was to examine experiences of mental health professionals regarding the assessment and treatment of maladaptive interpersonal behaviors, impulsive lifestyle, antisocial personality behaviors, and perceived commonality among these factors in known sex offenders. I used open-ended questions based on items from the following psychometric measures, respectively: the Interpersonal Closeness Measure (Berger, Heinrichs, von Dawans, Way, & Chen 2016), the Impulsivity Measure (Chan, Lo, Zhong, & Chui, 2015), and the Disturbing Behaviors Checklist II (Algozzine, 2011).

Research Design

Because I examined clinical reports of impulsive behaviors, maladaptive interpersonal behaviors, and antisocial behaviors, it was crucial to develop interview questions that elicit responses from mental health professionals who have experience treating sex offenders. I described impulsivity as high-risk among the previously examined sex offender group, by historically engaging in means of self-gratification. Erickson et al. (1987) reported almost half of his participants were chemically dependent, reducing inhibitions which normally reduced impulsivity.

In this research, I examined antisocial, impulsive, and maladaptive interpersonal behaviors by questioning history and behavioral observations by mental health professionals of various maladjustments, impulsive behaviors and callous coping mechanisms within the individual, similar to what Erickson et al. (1987) described in their research. This research provided evidence of difficulties with controlling

impulsivity, demonstrating empathy, and difficulties with establishing secure relationships.

Moustakas (1994) posited that truth that exists in what can be observed from many angles of subjectivity, which are sometimes lost through objective scientific methods in objective research. I chose the qualitative design for researching behaviors of sex offenders because it analyzes information obtained from interviewing mental health professionals providing treatment to sex offenders. As Moustakas (1994) suggested, focusing on the subjective evidence and studying the phenomenology of the raw observations of mental health professionals assisted in understanding of maladaptive interpersonal behaviors, impulsive lifestyle, antisocial personality behaviors, and perceived commonality among these factors in known sex offenders.

The design of this study was created in order to test the research questions:

Research Question 1: How do mental health professionals observe maladaptive interpersonal behaviors in individuals who are known sex offenders?

Research Question 2: How do mental health professionals observe impulsiveness in individuals who are known sex offenders?

Research Question 3: How do mental health professionals observe antisocial personality behaviors in individuals who are known sex offenders?

Research Question 4: How do mental health professionals see commonality among the behaviors reported corresponding to RQs 1–3 in individuals who are known sex offenders?

Sample size and population

For this research, I selected participants first-come from an initial pool of 50 mental health professionals who specialize in treating sex offenders and agreed to participate in this study. I prescreened the candidates to exclude criteria that could cross-contaminate the results with criteria from other groups. According to Krejcie and Morgan (1970), the minimum number of participants that could be accepted from the participant pool was 11, with a 95% confidence level and 5% margin of error.

Using a qualitative research design in this study, I captured how mental health professionals describe experiences regarding the assessment and treatment of maladaptive interpersonal behaviors, impulsive lifestyle, and antisocial personality behaviors among sex offenders and whether it is reported this population shares commonality among these psychological behaviors. Explanatory research allows the flexibility of open-ended questions during interviews, so further information could be gathered during the interview, more so than using yes-or-no questions.

I accomplished collecting data by conducting interviews of mental health professionals who have experience treating sex offenders, both released to the community and still incarcerated. The criteria for mental health professionals to participate in the interview was set to a minimum of 2 years of experience including post certification and state licensing, and having treated a minimum of 10 individuals convicted of a sex offense. If the mental health professional did not meet the experience criteria, I did not select him or her as a participant. I chose 11 participants based on whether he or she had adequate experience that meets the minimum criteria for this research.

The sample that I selected based on availability of the mental health professional to complete a telephonic or face-to-face interview. I sent recruitment flyers to outpatient and inpatient mental health facilities in the northeastern U.S. region, with a contact number for those interested in participating. I assigned volunteers on first-come-first-serve basis until I had 11 participants. Upon selection, I provided participants a follow-up questionnaire requesting demographic information (Appendix C), none of which was a determining factor for inclusion in this study as it was tallied as collateral information.

Interview

Participants agreed to conduct the interview either over the phone or in person, if the participant was available and was within a reasonable traveling distance. I asked questions from both the demographics questionnaire (Appendix C) and the interview questionnaire (Appendix D). I conducted the interviews via telephone for use exclusively for this research, ensuring safeguards and privacy of the participants. If the participant was unable to conduct the phone interview in its entirety, then the participant was able to opt out in the study, as no other means of an interview were allowed. If the participant had chosen to ask follow up questions regarding the purpose of the study, he or she was permitted. I added additional questions in Appendix D in order to permit further discussion of characteristics that are highly relevant to the research questions and allowed them to respond in a manner that seeks further rationale and interpretation of each of the three behaviors examined.

Because I used the results of the interview in a qualitative capacity, I asked all of the questions in the interview process in an open-ended format. I selected candidates by conducting a search in cities within a 250-mile radius for mental health professionals who

specialize in treating sex offenders. If an agency advertises mental health treatment, the agency received a recruitment flyer in the mail, requesting participants. Candidates who chose to participate in the research, I mailed the recruitment letter (Appendix A) and consent form asking for volunteers for an important qualitative study. After I had sent 50 applications, 11 were selected for initial interviews on a first-come-first-serve basis. Not all 50 initial recruits were qualified, for reasons such as not meeting criteria or natural attrition or absenteeism. I selected each participant who met the minimum criteria. I prescreened via the initial questionnaire by collecting demographic and historical data pertaining to the participants' years of experience, certification and licensure, and number of individuals treated. I did not select participants was based on race, age, socioeconomic status, or religion.

Measurement Approach

The setting option for interviewing all participants was either telephonic, from a private phone number, or through face-to-face interviewing at the participant's office or another neutral location. For this study, all of the participants elected the telephone interview. From a room that was appropriate for privately interviewing, I conducted the interview with the participant and provided for reduced chance of interruption. I made participants aware of the terms of use for information that they provided and informed of the purpose of this study. The necessary information and their consent were verified by signing the permission to conduct the interview and record the participants' responses to the interview questions (Appendix D). The supervisor of this study was available, if assistance was needed through the course of the interviews.

As previously mentioned, I selected the interview questions to allow participants to describe antisocial personality disorder, interrelationship difficulties, and impulsivity issues which they have observed. The interview was composed of seven items that I used to probe the participants' experience with sex offenders demonstrating antisocial personality behaviors, relationship difficulties, and impulsivity (Hare, 1991). The interview took around 20 to 45 minutes to complete as each item was designed as an open-ended question, allowing the participant time to discuss information relevant to that item.

Procedures

Prior to beginning the data collection, I asked all of the participants to sign an informed consent form, which notified them that all data collected is kept confidential, in accordance with the American Psychological Association "Ethical Principles of Psychologist and Code of Conduct" (APA Ethics Code, 2010). Each participant met for a telephonic or face-to-face interview. I explained confidentiality of the interview and data collection to each participant, both in the consent agreement and interviews. For purposes of confidentiality, I removed the names and identifying information from all recordings and documents as to ensure anonymity. During the interview, I recorded the participants' questions and responses. Following the conclusion of the interviews, I debriefed the participants on their responses and they were allowed to ask any questions regarding the purpose of the study. Additionally, I informed the participants of what the research is for and their specific role in the analysis of the data collected.

My use of the demographics questionnaire (Appendix C) assisted in qualifying the participant based on experience. Careful consideration was taken when I designed the

questionnaires to eliminate any questions that may lead to participants' disclosure of personal identifiable information about specific clients. All items on the demographics questionnaire were closed-ended questions, to avoid the need to assess participants' responses that do not meet the criteria of this research.

Confidentiality and anonymity of the participants and their clients were of the greatest importance in this study. I instructed the participants not to disclose clients' personal information during the interview process. Aside from the initial list of names and contact information of the participants, which were already publicly available on websites, I did not retain any personal identifiable information. I kept all interview and questionnaire items under the participants' assigned numbers and did not associate that information in any way with other personal identifying information. Participants consented to participate in this study, verified by their signature on the consent form, and were able to verbally opt out of the study at any point. All information collected will be destroyed no more than 6 months beyond approval of the final study. I will accomplish the destruction of electronic files by deleting them from the encrypted hard drive. Additionally, I will shred all hardcopy notes and forms using a cross-cut shredder.

After I concluded the interviews, the audio-recorded interviews were transcribed into a Word document. I reviewed and analyzed each statement in the transcription made by me and the participants for relevance to the research questions. Those whom I had determined to be relevant were abstracted and labeled as to its level of horizontalization across participants' responses, similar to how Moustakas (1994) suggested similar interviews should be conducted. During this process, I detected common words and themes to the participants' responses to the interview questions relating to maladaptive

interpersonal behaviors, impulsive lifestyle, antisocial personality behaviors, and perceived commonality among these factors in known sex offenders.

The process of reviewing transcribed interviews was also incorporated into the identification of invariant constituents, which Moustakas (1994) explains as the analysis of expressions necessary for understanding participants' experiences. It also excluded vague or repetitive expression of the participants (Moustakas, 1994). These served as a guide to develop structural descriptions of reported experiences by the participants.
In addition to protecting the personal identifying information, I further determined in this research that participants for this study were not protected as a vulnerable class of participants, in accordance with the Institutional Review Board (IRB) Guidebook (OHRP, n.d). The IRB approval number for this study is # 01-09-18-0105767. Under no conditions were participants offered compensation or additional pay for participating in this study. However, it may be possible that mental health professionals who work with sex offender populations may experience negative psychological traumatization. Due to the potential risk of psychological impact that may have been inadvertently triggered during the interview process, participants who identified during the debriefing as having experiencing psychological distress, would have been referred to Walden University's Research Participant Advocate listed on the consent form (Appendix B) in order to be connected with options for therapeutic services.

Summary

The purpose of this research was to examine experiences of mental health professionals regarding the assessment and treatment of maladaptive interpersonal behaviors, impulsive lifestyle, antisocial personality behaviors, and perceived

commonality among these factors in known sex offenders. Through this research, I identified patterns that predominantly exist in those offenders. Finding those patterns of behavior in known offenders should help identify those who may benefit from intervention programs or perhaps help future initiatives to tailor treatment programs with the goal of reducing sexually based crimes. Additionally, all qualitative data collected and analyzed in this research could assist in development of future qualitative research, by providing a foundational description of impulsivity, maladaptive interpersonal behaviors, and antisocial behaviors observed by mental health professionals. Sexual offenses continue to burden society and further strain the judicial system. For the psychological community, sex offenders' actions produce victims who usually suffer from mental or emotional disorders (Berlin, 2003). This research is a positive step toward proactively seeking out a solution to prevent and minimize the problem as opposed to treating the problems in the aftermath.

Additionally, the cost-benefit of identifying mental health professionals' perceptions and experiences of psychological behaviors and commonalities among those behaviors of sex offenders is of great benefit to society. Such research could provide the mental health community evidence to assist in establishing treatment programs with the goal to reduce recidivism rates among the sex offender population. Funding research for detecting high-risk sex offenders and recidivists ultimately could lead to identification and treatment, thus minimizing the number of victims in society. Victims of sex offenders are also a factor of the economical strain from such crimes. A great deal of money is allocated toward investigating, prosecuting, incarcerating, treating, and tracking convicted sex offenders. If a fraction of that money is used to create programs to identify

and treat individuals to prevent them from committing the offenses, much of that money may be saved in the end.

Chapter 4: Results

Purpose

The purpose of this research was to examine reported experiences of mental health professionals regarding the assessment and treatment of maladaptive interpersonal behaviors, impulsive lifestyle, antisocial personality behaviors, and perceived commonality among these factors in known sex offenders. In this chapter, I present the findings of this research. Through this research, I examined the experiences of mental health professionals who provide treatment to sex offenders. Specifically, I examined whether or not participants reported a commonality when providing treatment in observed and reported difficulties with relationships, impulsivity, and antisocial behaviors.

In this chapter, I took appropriate steps to conduct a qualitative analysis of the data and respective findings are presented. The qualitative analysis of the data collected produced the findings of this research and answered the research questions in terms of known characteristics of sex offenders. A sex offender is defined as any individual who has been charged and convicted of violating state or federal laws and are of a sexual nature (Megan's Law Public, 2016). Participants were in the practice of counseling or therapy, with the primary goal of treating sex offenders. I derived common terminology for this study from past research and from the participants, as used in the field of sex offender treatment. In this chapter, I presented the data of the participants of this study, as to afford the reader adequate insight to their level of experience, demographic details, level of education and experiences providing treatment. The participants were trained in working with individuals who have committed sexual offenses, having provided them

therapy to adjust to life outside of prison, and having assessed them for risk of recidivism.

Research Setting

The setting for this research was a telephonic interview process, where I contacted participants by telephone number that they provided in their consent letters. The participants conducted the interview via a landline, if possible, as to reduce the likelihood of dropped calls and breaks in audio. I emphasized clarity in the interview, so that a good transcript could be produced. If the participant was unable or uncomfortable using a landline telephone, I allowed a cell phone interview. Out of the 11 participants, two participants opted to conduct the interview via cell phone.

In addition to the preferred method of contact, I asked the participants to allot 60 minutes for the interview. I conducted a dry-run of the interview with a nonparticipant in order to practice the flow of the questions and gauge the approximate total length of the interview. The average length of each of the 11 items took about 2–4 minutes, totaling approximately 30 minutes. I allotted three minutes prior to the interview to describe the interview process itself. Additionally, I allotted time after the interview for debriefing, answering participant questions, and providing any additional information that the participants requested. Including the pre-brief and debrief, I informed participants that the phone call could be expected to last about 45 minutes. I apportioned an additional 15 minutes to allow for any possible technical issues, longer responses, follow-up questions during the interview, inquiries by the participant or me the interviewer, and any other unforeseen situations that might warrant additional time.

When I contacted participants to set up the interview time, I asked them to conduct the telephonic interview in an environment that was private and distraction free. Such an environment would allow for the participants to provide the best account of their experiences and remain focused throughout the entire interview, without interruption.

Demographics

In this study, I mailed 50 recruitment letters to therapists who were identified by searching on Google.com for "Pennsylvania sex offender therapists." These professionals reported that they had the proper experience and training to provide mental health services to people who were convicted of sexually based offenses. Out of the 50 potential candidates, 11 candidates responded and met the criteria, as outlined in the recruitment letter: a) having a professional counseling license, b) having 2 or more years of experience in treating sex offenders, c) treated 10 or more sex offenders, and d) fluent in the English language. All 11 participants signed consent forms and agreed to conduct their interviews telephonically at a time that was convenient for both the interviewer and participant.

The two age ranges that the participants fell into were 30–55 and 56 or older. Four participants reported their ages as 30–55, with the remaining seven reporting that they were 56 years or older. A majority of the participants were women (seven) and four were men. All 11 participants identified White or Caucasian as their race. As for years of experience providing therapeutic services to sex offenders, nine participants reported having 11 years or more, one participant reported having 6–10 years, and one reported having 2–5 years. All 11 participants reported treating over 100 clients who were sex offenders, and all participants indicated that they had obtained specialized training for

treating this population. Ten of the participants had obtained their master's degree in either social work, counseling, or psychology, while one had obtained a doctorate degree in psychology, social work, counseling, or closely related field. All participants answered all demographic questions and the interview items; thus, no specific question or item is underreported in the findings and results.

Data Collection

On the day of the interview, I informed each participant that a) the interview was recorded for transcription purposes, b) there were seven demographic questions (Appendix C), c) there were 11 interview items (Appendix D), and d) no names of clients or the participant were to be used, as to ensure anonymity and confidentiality. After the participants approved consent to record the phone call, each interview was recorded locally to the researcher's cell phone's storage. After each interview concluded, I transferred the recording to an encrypted and password-protected SD card. Each recording was then transcribed to a respective MS Word document and stored on the encrypted SD card. Each recording had its own transcription. Then, I deleted all copies of recordings and transcriptions that were not stored on the encrypted SD card from the phone and hard drive, then I emptied from the trash folder.

There were 11 open-ended questions asked of the 11 participants during the interview (Appendix D). Nine of the questions were selected from three sources, the Interpersonal Closeness Measure (Berger et al., 2016), the Impulsivity Measure (Chan et al., 2015), and the Disturbing Behaviors Checklist II (Algozzine, 2011). The remaining two questions were designed to allow additional experiences to be reported outside of the

construct of examining relationship difficulties, impulsivity, and antisocial behaviors. I designed this study in order to test the following research questions:

Research Question 1: How do mental health professionals observe maladaptive interpersonal behaviors in individuals who are known sex offenders?

Research Question 2: How do mental health professionals observe impulsiveness in individuals who are known sex offenders?

Research Question 3: How do mental health professionals observe antisocial personality behaviors in individuals who are known sex offenders?

Research Question 4: How do mental health professionals see commonality among these behaviors in individuals who are known sex offenders?

Items 1 and 2 from the interview questions (Appendix D) were related to Research Question (RQ) 1, pertaining to maladaptive interpersonal behaviors. Items 3 and 4 from the interview questions are related to RQ2, pertaining to impulsivity. Items 5, 6, and 7 from the interview questions related to RQ3, pertaining to antisocial personality behaviors. Items 8 and 9 were provided to further discuss experiences with RQs 1, 2, and 3. Items 10 and 11 allowed for further discussions to find other commonalities in behaviors among sex offenders, as it relates to RQ4.

I reviewed all 11 interview transcriptions for themed content relating to the research questions with which they are associated. If the participant positively reported the theme, I counted it and coded as a positive hit. RQs 1–4 addressed participant feedback regarding their client's interpersonal relationships, impulsivity, antisocial behaviors, and other psychological traits respectively. Then, I tallied up each interview and the coded themes were totaled for each RQ. For RQs 1–3 only themes that the

participants positively reported were coded and recorded. All other behaviors for RQ4 items were coded and recorded.

In addition to coding and recording reported themes relative to each of the RQs, I reviewed the interview transcripts for other reported common themes and behaviors by participants across all interview items. This was done to expand the search for other commonly observed behaviors, in order to assist with answering RQ 4. In order to categorize the coding and presentation of the themes, the interview items were truncated as follows:

Research Question 1

RQ1 asked "How do mental health professionals observe maladaptive interpersonal behaviors in individuals who are known sex offenders?" In Item 1, I addressed maladaptive interpersonal relationships by asking "How close have you observed or had clients who are treated for sexual offense self-report difficulties with maintaining close relationships with others?" In Item 2, I addressed how the sex offender daring about others by asking "How have you observed or had clients who are treated for sexual offense self-report difficulties with caring about others?"

Research Question 2

RQ2 asked "How do mental health professionals observe impulsive behaviors in individuals who are known sex offenders?" In Item 3, I addressed the lack of controlling impulses among sex offenders by asking "How have you observed or had clients who are treated for sexual offense self-report difficulties with controlling their impulses?" In Item 4, I addressed the lack of resisting temptations among sex offenders

by asking “How have you observed or had clients who are treated for sexual offense self-report difficulties with resisting temptations?”

Research Question 3

RQ3 asked “How do mental health professionals observe antisocial personality behaviors in individuals who are known sex offenders?” In Item 5, I addressed the lack of social responsibility among sex offenders by asking “How have you observed or had clients who are treated for sexual offense self-report difficulties with being able to assume social responsibility?” In Item 6, I addressed the difficulty with social situations among sex offenders by asking “How have you observed or had clients who are treated for sexual offense self-report difficulties with social situations, involving verbal communication with others?” In Item 7, I addressed the lack of empathy among sex offenders by asking “How have you observed or had clients who are treated for sexual offense self-report difficulties showing empathy?”

Research Question 4

RQ4 asked “How do mental health professionals see commonality among the behaviors reported corresponding to RQs 1–3 in individuals who are known sex offenders?” In Item 8, I addressed the theme of the most common among sex offenders: maladaptive interpersonal relationships, impulsivity, or antisocial behaviors by asking “What would you consider the most prevalent and commonly observed trait in your treatment of sex offenders in terms of difficulties with maintaining relationships, impulse control, and antisocial personality behaviors?” In Item 9, I addressed the theme of most challenging in treatment: maladaptive interpersonal relationships, impulsivity, or

antisocial behaviors by asking "Which of those behaviors do you find to be the most challenging when treating individuals who have committed sexual offenses?"

Within RQ4, I elicited other information and common behavioral traits, not pertaining to maladaptive interpersonal relationships, impulsivity, and antisocial behaviors among sex offenders. In Item 10, I asked "Are there any additional behaviors or difficulties, other than issues with maladaptive inter-relationship issues, impulse control, and antisocial behaviors, that you have observed to be relatively common among sex offenders?" In Item 11, I asked "Is there anything you would like to ask or any additional comments you would like to provide that you feel is relevant for the direction of this study?"

Data Analysis

For this research, I labeled the interview Items 1–11. I coded the themes and counted as a hit, if a participant reported the theme. If a participant did not report a theme, did not mention a theme, or offered comments that were contrary to the positive reporting of a theme, the I did not code the comments as a hit. The research questions were designed to look for specific common behaviors, and it is important to preserve the nature of this research. The targeted behaviors were coded as either present or not present.

Research Question 1

Item 1

In Item 1, I addressed difficulties in maintaining close interpersonal relationships. Participants indicated that there is commonality in reported problems with interpersonal relationship issues. I asked in Item 1 "How close have you observed or had clients who

are treated for sexual offense self-report difficulties with maintaining close relationships with others?" Participant 1 reported this item by saying, "I've observed it quite frequently. Well, both, I've had clients self-report and then I've also had clients report difficulties developing intimate relationships." Participant 2 reported this item by saying, "I say yes, the overwhelming majority have difficulty forming relationships with other human beings." Participant 3 reported this item by saying, "Constantly. In terms of, I see that all the time with my clients in terms of relationships with others." Participant 4 reported this item by saying, "In that population, there seems to be an extraordinarily higher number of adult males even as old as like 40s and 50s who have never had an intimate relationship with anybody which I think it's unique to that group." Participant 5 reported this item by saying, "I would say that most of the experiences that I've had with people who had molested children I would say under 14 seem to have personal relationship difficulties with adults." Participant 6 reported this item by saying, "Yeah. I would say maybe 80% or more. I mean, obviously, the question, I mean, the offense itself kind of alludes to a problem with close relationships." Participant 7 reported this item by saying, "So, I would describe their ability to maintain and form relationships as poor." Participant 8 reported this item by saying, "On the surface they're able to, but when he gets down to the relationships, that's not saying all experience really a lot of difficulty with relationships, interacting with others." Participant 9 reported this item by saying, "It's establishing healthy and meaningful sexual and/or emotional relationships with people. And I've found, over the course of this treatment, that they struggle to have a balance of the two." Participant 10 reported this item by saying, "Well, I would say a majority of my guys struggle to have healthy relationships."

Item 2

In Item 2, I addressed difficulties with caring about others. Participants indicated that there is commonality in reported problems with caring about others. I asked in Item 2, "How have you observed or had clients who are treated for sexual offense self-report difficulties with caring about others?" Participant 2 reported this item by saying, "So, I would say the answer is yes, but not a large number would admit actually caring about another human being." Participant 3 reported this item by saying, "Caring about others is more focused toward my individuals that are diagnosed with more of the sociopaths; the anti, we would diagnose with antisocial personality disorder." Participant 4 reported this item by saying, "But there's always a component in that group who meet criteria and are antisocial personality characters." Participant 5 reported this item by saying, "I find the majority of them very self-serving, very literal sense that they'd harm somebody for their own gratification. I just don't see them having that sense that-- I mean, in other words, their behavior was, for me-- they weren't concerned about anything else." Participant 6 reported this item by saying, "So, they're not saying that they're having a hard time caring for others so much as how their caring might be problematic or conflictual, just relationship kind of skills, conflict kind of skills, things like that." Participant 8 reported this item by saying, "…you get a mixture of-- some are very self-centered and they have very little empathy for anyone. And we'll have some, I would say, kind of an even mix and I don't know if that's the norm or not." Participant 10 reported this item by saying, "Absolutely, we have guys that have very limited skills in being able to show care and concern for other people." Participant 11 reported this item by saying,

“I would say that empathy in general and caring about others is something that is difficult across the board.”

Research Question 2

Item 3

In Item 3, I addressed difficulties with controlling impulses. Participants indicated that there is commonality in reported lack of control of impulses. I asked in Item 3, “How have you observed or had clients who are treated for sexual offense self-report difficulties with controlling their impulses?” Participant 1 reported this item by saying, “That’s been frequent, especially with the younger, the statutory offenders.” Participant 2 reported this item by saying, “Yes. We do standard test. Everybody has a psych eval eventually done within the first year. And impulsivity is a big target area.” Participant 3 reported this item by saying, “Impulses, yeah, many of my guys have drug and alcohol issues and some of them used to be drug dealers. Their impulses, well they all made bad decisions, otherwise they wouldn’t be before me, let’s put it that way.” Participant 4 reported this item by saying, “The first group are male pedophiles whose victims were young boys. Even more so than male pedophiles whose victims were female, or female and male. But especially the guys who had young boys, adolescent boys. I don't see them effectively being able to control those impulses over extended period of times. I see them be able to maintain control for maybe a year or two.” Participant 5 reported this item by saying, “I would say that prior to treatment, they've had very, very difficult times stopping doing what they're doing. A common thing that I have heard with sex offenders is, ‘I kept telling myself I shouldn't be doing this but I couldn't stop okay.’” Participant 6 reported this item by saying, “So, they might have addiction issues, drinking or smoking, or other kind of

things that they use to help with their impulse control, to help create impulse control. But yeah. They have a lot of issues with that." Participant 7 reported this item by saying, "There is definitely a crossover between, it isn't just the impulsive sexual behavior that I've seen. It overlaps. So that would go back to my original answer. The ones that are able to control their impulsive sexual behavior are also able to stay away from other types of impulsive behavior." Participant 8 reported this item by saying, "They'll want to portray that they are able to control a lot of that, but once you really get into the therapy, they recognize that they do have a lot of difficulty with impulse control, which allows them to go through the thought process, move forward." Participant 9 reported this item by saying, "I think that impulse control should be a very focal point of treatment, whether it's quitting a job without thinking about the consequences, getting into a relationship without thinking things through." Participant 10 reported this item by saying, "For our guys that struggle with deviant sexual thoughts, impulsivity for them, that tends to go hand and hand." Participant 11 reported this item by saying, "A lot of anger control issues, a lot of stuff with difficulties keeping jobs because they have conflicts with coworkers or supervisors."

Item 4

In Item 4, I addressed difficulties with resisting temptations. Participants indicated that there is commonality in reported problems with resisting temptations. I asked in Item 4, "How have you observed or had clients who are treated for sexual offense self-report difficulties with resisting temptations?" Participant 1 reported this item by saying, "Most everyone identifies some area where they have difficulty, whether it be drug and alcohol, spending, porn, you know other sexually compulsive behavior, I group all of them

together.” Participant 2 reported this item by saying, “Yes. Once the trust is established, then they tend to talk about their triggers, i.e. resisting temptations.” Participant 3 reported this item by saying, “Yeah, the main one with my exhibitions” Participant 4 reported this item by saying, “And so many, many years and many, many groups there's always a discussion that arises about how challenging it is for them to be exposed to individuals with less clothing on if that makes sense.” Participant 5 reported this item by saying, “I would say that the majority of them, prior to treatment, if the opportunity presented itself, they had much difficulty in not acting out.” Participant 7 reported this item by saying, “Well, I do think that it is a daily struggle with them. I would compare it to an addiction. You have to make a daily choice to not engage in temptations, or impulse, or risky behaviors. So, the struggle is a daily.” Participant 8 reported this item by saying, “Once you're an addict, you're always going to struggle with it, it's never like a cure, it's not like they are able to medically cure you or something.” Participant 9 reported this item by saying, “It's resisting the temptation to go back to old habits and even developing healthy fantasies without using pornographic materials becomes such a struggle for them.” Participant 10 reported this item by saying, “Yeah. I mean, I guess I don't really have a percentage. I think, do I see more than 50% of the guys struggling with--” Participant 11 reported this item by saying, “Yeah. I would say again with a lot of-- in those ways yes. Using substances is peer pressure. Seems to be a downfall of a lot of people.”

Research Question 3

Item 5

In Item 5, I addressed difficulties with social responsibility. Participants indicated there is commonality in reported problems with accepting social responsibility.
I asked in Item 5, “How have you observed or had clients who are treated for sexual offense self-report difficulties with being able to assume social responsibility?” Participant 1 reported this item by saying, “Lifestyle stability is always a focus of treatment, because most of them, you know I’ve treated offenders at all different stages of the legal processes.” Participant 2 reported this item by saying, “Yes. Very much.” Participant 3 reported this item by saying, “Yeah, I've had several, again it is a large population. Guys that do not pay their child support, guys that continue to be involved in domestic violence issues.” Participant 4 reported this item by saying, “And then there's the other end of that spectrum is I have people who have the same opportunities in the same areas complain for months on end that they can't get a job because they're a sex offender.” Participant 7 reported this item by saying, “Some people take total responsibility and attempt to make amends, and pay back to their families, their victim, society in general. And others have total disregard for their responsibility.” Participant 10 reported this item by saying, “Yes, we have a few people that are lazy, and they don't want to get up and really do the work that's necessary to get a job, but they want to work, and they can get hired.” Participant 11 reported this item by saying, “So, what we often see is somebody will take 2% of the responsibility and call that taking responsibility, but then be very quick to diffuse 98% of it among everybody else and believe that that consists of taking responsibility.”

Item 6

In Item 6, I addressed difficulties with social situations. Participants indicated there is commonality in reported problems with social situations. I asked in Item 6, "How have you observed or had clients who are treated for sexual offense self-report difficulties with social situations, involving verbal communication with others?" Participant 1 reported this item by saying, "Well, some of them experience some level of social anxiety or social reactivity due to the situation that they're in." Participant 2 reported this item by saying, "That's limited but yes. That would definitely be a lower percentage, maybe 5 or 10 percent. A lot of them have the gift of gab." Participant 3 reported this item by saying, "Yeah, yeah, like I said you have a lot of guys who don't know how to--- You try to help them get back into the community and live in the community and be functional. It's difficult because there's a lot of self-esteem issues and, of course, with their offense, it's like wearing a scarlet letter on your head." Participant 4 reported this item by saying, "I would think that's a pretty huge issue with this group in treatment." Participant 5 reported this item by saying, "Well, I can't say that what percentage of that but it is a common thread through the sexual offending population that they seem to gravitate more to an immature individual as opposed to someone who would be more likely to engage them in social dialogue." Participant 6 reported this item by saying, "Yeah. Certain kind of clients seem to have that more than others. Like the child porn clients, they have very weak social skills." Participant 7 reported this item by saying, "I think that that is one of the most prevalent characteristics. They are socially inept would by my opinion." Participant 8 reported this item by saying, "That they're fearful of social activities, you know, socializing people because it's a protective factor. They don't want to be accused of anything sexual, they avoid family functions and different places." Participant 9 reported

this item by saying, “Yes. Definitely. We have to spend a lot of time on communication, and effective communication, and what does that mean, and saying what you mean, and meaning what you say.” Participant 10 reported this item by saying, “So, some of our people, they have extreme anxiety when they first get out of prison or jail, just like reintegrating back into society, and just worried about, ‘Everyone knows that I'm a sex offender. Everyone knows I'm on Megan's law.’” Participant 11 reported this item by saying, “That again goes back to, I think, the social skills not isolation. It seems to be a struggle to participate in healthy society.”

Item 7

In Item 7, I addressed difficulties with empathy. Participants indicated that there is commonality in reported problems with expressing empathy. I asked in Item 7, “How have you observed or had clients who are treated for sexual offense self-report difficulties showing empathy?” Participant 1 reported this item by saying, “There are those I see them less rarely in community settings where they just have the antisociality that is characterized by lack of empathy toward anyone.” Participant 2 reported this item by saying, “I’d say the majority of them meaning 51% or more have empathy and they’re remorseful for their crimes, but there are a good handful that are sociopaths and cannot feel empathy.” Participant 3 reported this item by saying, “Yeah. To a degree, again, their empathy is one of the hallmarks of their crime because they're hurting people and you have to be able to block that out in order to do that.” Participant 4 reported this item by saying, “The reality though, and I've had many, many in-depth discussions with many, many groups and individuals, they really, for the most part, lack a sense of what that even means, and truly do not have an understanding about hurting somebody or thinking about

that as a way to prevent acting out." Participant 5 reported this item by saying, "You won't get parole if you don't go through treatment and take responsibility but I don't see that the genuineness I guess is what I'm looking for. I don't see the genuineness in their responses." Participant 7 reported this item by saying, "I've had clients who know that that, as a therapist, that's what I'm looking for. So, I've had some clients be over empathetic and not mean it, manipulate empathy." Participant 8 reported this item by saying, "It's something that's more observable. When they're speaking, you can pick up on it." Participant 9 reported this item by saying, "It seems like they hardly ever think about what would happen if the roles were reversed. And as soon as they think about that, they seem to get it like, 'Oh, geez, no, I would hate that.'" Participant 10 reported this item by saying, "And so, empathy it's a concept that a lot of them really did not understand prior to getting into treatment." Participant 11 reported this item by saying, "Well, I think part of that, number one, is seeing themselves the victim like I said. But part of that is also, number one, a lot of people would come from backgrounds where showing any kind of emotion at all was viewed as weak or not desirable."

Item 8

In Item 8, I addressed the most common traits among sex offenders being either maladaptive interpersonal relationships, impulsivity, or antisocial behaviors. Participants indicated that there is commonality in reported problems among the three traits. I asked in Item 8, "What would you consider the most prevalent and commonly observed trait in your treatment of sex offenders in terms of difficulties with maintaining relationships, impulse control, and antisocial personality behaviors?" Participant 1 indicated

commonality with relationship issues, “I would just have to say across all boards, across all categories, I would see social relationships and social skills as the biggest problem.” Participant 3 indicated commonality with relationship issues, “I would say relationships, yeah.” Participant 5 indicated commonality with relationship issues, “So, I think it takes them a very long time to understand how to effectively socialize and how to live an open life because they've lived a double standard, they've lived a double life.” Participant 7 indicated commonality with impulsivity, “I'd say impulse control.” Participant 8 indicated commonality with antisocial behaviors, “I think that it's the antisocial personality disorder. And especially really beginning in the treatment.” Participant 9 indicated commonality with impulsivity, “Gosh, it's really a toss-up between interpersonal relationship and impulse control, but I'd probably have to go with impulse control because we also have a lot of guys that have had really long-term relationships and/or they're married, and they've maintained marriages through their sexual crimes and still have their relationships somehow.” Participant 10 indicated commonality with relationship issues, “I would say the difficulty in the social and maintaining relationships…” Participant 11 indicated commonality with relationship issues, “Relationships, I would say, is lack of skills. And that could be either from choice, whether that's a self-imposed, ‘I don't want to build those,’ or, ‘I don't have the capacity to build those.’”

Item 9

In Item 9, I addressed the most challenging traits among sex offenders being either maladaptive interpersonal relationships, impulsivity, or antisocial behaviors. Participants indicated that there are commonly challenging behaviors in reported

problems among the three traits. I asked in Item 9, “Which those behaviors do you find to be the most challenging when treating individuals who have committed sexual offenses?” Participant 1 identified relationship issues as the most challenging behavior, “I think most challenging would be the social skills and social relationships, just because everybody is so different and has, each situation is so individualized with what the resources are and what the obstacles are.” Participant 2 identified impulsivity as the most challenging behavior, “So, it would be between impulsivity and… It’s really a tossup between the first two. 50/50.” Participant 3 identified antisocial behaviors as the most challenging behavior, “Okay. In terms of the challenging-- like I said, with the highest risk guys, like the psychopaths and hardcore sociopaths. I could do so much with them, okay?” Participant 4 identified impulsivity as the most challenging behavior, “Impulse control played out in a thousand different ways with sex offenders quite so I hear people talk about blow ups at work.” Participant 6 identified antisocial behaviors as the most challenging behavior, “Antisocials are more like, very much more narcissistic. And it's hard to soften that trait.” Participant 7 identified antisocial behaviors as the most challenging behavior, “I would say the antisocial because it would be the most difficult.” Participant 8 identified antisocial behaviors as the most challenging behavior, “Well, definitely the antisocial personality, definitely. I mean, that's part of your personality, how do you change that?” Participant 9 identified relationship issues as the most challenging behavior, “So, I'd have to say, again, interpersonal relationships because they might really struggle with how to actually interact with another human.” Participant 10 identified antisocial behaviors as the most challenging behavior, “Antisocial [laughter]. Yeah. Yeah. I mean, yeah, that's not impossible, but I think most challenging.”

Participant 11 refers to the answer provided for Item 8 relationship issues as the most challenging behavior, “Relationships, I would say, is lack of skills. And that could be either from choice, whether that's a self-imposed, ‘I don't want to build those,’ or, ‘I don't have the capacity to build those.’”

Item 10

In Item 10, I addressed the other common traits among sex offenders outside of maladaptive interpersonal relationships, impulsivity, or antisocial behaviors. Participants indicated there is commonality in reported problems among sex offenders. I asked in Item 10, “Are there any additional behaviors or difficulties, other than issues with maladaptive inter-relationship issues, impulse control, and antisocial behaviors, that you have observed to be relatively common among sex offenders?” Participant 1 identified poor coping strategies and depression and anxiety as other common traits, “Use of sex to cope comes to mind and lack of affective emotional coping.” Participant 1 continues, “For others, it may be depression or anxiety.” Participant 2 identified victim mentality as another common trait, “It’s the victim mentality. Everybody is a victim these days and they use that as an excuse for their behaviors or as an excuse to not getting a job or getting out of bed or volunteering.” Participant 3 identified victim mentality, self-esteem issues, and history of abuse as other common traits, “The issues I think a lot of it has to do with their own personal trauma. So, trauma work is important with these guys, from their own abuse.” Participant 4 identified victim mentality and self-esteem issues as other common traits, “I think, one of the traumatic barriers for them is their level of shame. Shame about maybe how they've embarrassed their family, shame about what they did, shame that is carried over from childhood issues.” Participant 4 continues, “And it's

almost like it plays out that, underlying, I think they believe that if they ever stopped feeling ashamed, they might re-offend. That's a tough issue to work with." Participant 5 identified trust issues and victim mentality as other common traits, "And that is, they almost all have an overwhelming anger toward the legal system that they are bound to and the requirements that they have because of what they've done." Participant 6 identified victim mentality as another common trait, "Or a forgetfulness of their own childhood, or a lot of their own abuse issues, right, that they totally tuned out and desensitized to, and that gave them the ability to continue reoffending." Participant 9 identified poor coping strategies and chemical imbalance as other common traits, "Pornography is creating really misunderstood concepts of what a real sexual relationship looks like and generating unrealistic sexual expectations in a real-life relationship." Participant 9 continues, "…they're not getting the same high, the same dopamine high, from therapy that they would get from that same rush that they get from the pornography." Participant 10 identified self-esteem issues and trust issues as other common traits, "I think a big piece that we also address here in our program is helping them just get past the shame of the crime and the stigma that the label gives them, and their sense of their self-worth and all that." Participant 10 continues, "I think we've done a really good job at making sure that there's a connection there with the probation or parole officer because you need them to be kind of working with you, and understanding the client and their issues." Participant 11 identified history of abuse as other common traits, "…it's just a high level of unresolved trauma that continues to complicate their treatment..."

Item 11

In Item 11, I addressed other comments pertaining to traits among sex offenders. Participants indicated that there is commonality in reported problems among the sex offenders. I asked in Item 11, “Is there anything you would like to ask or any additional comments you would like to provide that you feel is relevant for the direction of this study?” Participant 2 identified trust issues as an additional area of concern, “And I get to meet a lot of people that work with sex offenders and the biggest issue is trying to get the sex offender counselor moving from a punitive type of disposition to a therapeutic disposition. Their job is not to be punitive, but for some reason, it’s been hardwired into their brains that they have to be… That there’s some type of attitude or retribution.” Participant 5 identified trust issues as an additional area of concern, “Well, obviously, if they don't trust you, you can't help them. And so, over the years, it's been my policy, always, no matter whether I'm doing group or individual or I'm doing an assessment, is that I try to communicate to that individual that I respect them as a person.” Participant 6 identified trust issues as an additional area of concern, “But the role of the parole officer is a very heavy law-enforcement kind of quality to the supervision. And so, they sit in on groups and things like that. And so, of course, you can tell the way the group shares that night when the parole officer's there, there's a lot of trust issues. So, they're not as talkative or as revealing when the parole officer's there.” Participant 8 identified trust issues and history of abuse as additional areas of concern, “I mean, you try to look on the surface of all of this and here was a man that really, seriously injured a child. He himself was molested and abused much in the way of treatment that nobody believed him.” Participant 9 identified history of abuse as an additional area of concern, “I hope that as a result of understanding the perspective of therapists doing this work across the state, that

more people will really start to adapt the trauma-informed treatment model because it's just going to make it more effective as far as risk versus resiliency and decreasing recidivism." Participant 10 identified feeling isolated as an additional area of concern, "Well, again, isolation can be a huge issue for some of our guys." Participant 11 identified poor coping strategies and history of abuse as additional areas of concern, "I think, for at least, probably 80% of them it is a childhood issue, whether due to some form of a cognitive issue they did not develop it whether it is like I said, we see a lot of people who've been through multiple foster placements, or their parents have been abusive, or they just never had the attention or the ability to develop those skills, or they've been raised in households where criminal behavior was modeled."

Through the results, I showed varying degrees of commonality in participant responses across the 11 items. In Table 1, I reported the number of participants who provided a positive response, which indicated that they have experienced or observed a trait among their clients. In interview Item 10, I asked participants to identify "the most common" among maladaptive interpersonal relationships, impulsivity, and antisocial behaviors which were included to determine which of the three behaviors would the participants find to be most prevalent among their clients. Similarly, I asked participants which behaviors were "most challenging," to determine which behaviors were the most problematic to treat in the participants respective settings.

Table 1

Number of Reported Items by Participants

Research Question	Item	*n*	Number Positive Reported
RQ 1	Item 1	11	10
	Item 2	11	8
	Item 8	11	5
	Item 9	11	3
RQ 2	Item 3	11	11
	Item 4	11	10
	Item 8	11	2
	Item 9	11	2
RQ 3	Item 5	11	7
	Item 6	11	11
	Item 7	11	10
	Item 8	11	1
	Item 9	11	5
RQ 4	Item 10	11	9
	Item 11	11	7

Items 1–9 of the interview items were directly related to RQs 1–3. I provided Items 10 and 11 to afford participants the opportunity to report experienced or observed behaviors of their clients, that were not elicited in Items 1–9 and not pertaining to maladaptive interpersonal relationships, impulsivity, and antisocial behaviors. The additional traits and behaviors were listed in Table 2.

Table 2

Other Themes Reported by Participants

Other Themes	Participants Reported
Poor coping strategies	3
Trust issues	4
Sociopathic behaviors	2
Emotional immaturity	1
Chemical imbalance	1
History of abuse	4
Self-esteem issues	3
Feeling isolated	1
Anger	1
Victim mentality	4
Depression / anxiety	1

Evidence of Trustworthiness

For this study, I recorded each of the participants' audio interviews and transcribed them verbatim to a text document. The transcriptions were available for review by committee members or other reviewing bodies associated with this research for further analysis and credibility. The participants' discussion of their professional observations and experiences were believed to be credible and trustworthy as the participants were state licensed in their respective professions. Additionally, I provided excerpts of the transcriptions within this chapter to support the legitimacy of the interviews and the collected data.

Summary

In Chapter 4, I provided the data for this research and detailed procedures for how the data was collected and coded for analysis. I conducted all 11 interviews telephonically and all participants answered all 11 questions completely. There were no incomplete interviews or disruptions with any of the interviews. Using Microsoft Word Documents, I coded the participants' responses to determine if they indicated the presence of the behaviors described in each of the 11 items presented. In the results, I showed that, in terms of the research questions, a majority of the participants reported hearing and/or observing maladaptive interpersonal relationship behaviors, impulsivity, and antisocial behaviors when providing therapy to clients who are sex offenders.

In RQ1, I examined how participants discussed behaviors relating to maladaptive interpersonal relationships when providing therapy to sex offenders. Out of the 11 participants, 10 reported hearing and/or observing maladaptive interpersonal relationship behaviors, impulsivity, and antisocial behaviors when providing therapy to clients who are sex offenders by positively answering for Item 1 pertaining to maladaptive interpersonal relationship traits. Eight participants answered Item 2 as having treated sex offender clients who presented with issues or concerns over caring about others. In Item 8, I asked participants about the prevalence of maladaptive interpersonal relationship issues over impulsivity and antisocial behaviors; only five participants reported this to be the case. In Item 9, I asked participants to pick which of the three observed behaviors were the most challenging to treat, three participants stated that antisocial behaviors were most challenging to treat among sex offenders.

In RQ2, I examined how participants discussed impulsivity when providing therapy to sex offenders. All 11 participants reported observing a lack of controlling impulses (Item 3) and ten participants reported observing a lack of resisting temptations (Item 4). Two participants reported the prevalence of impulsivity over antisocial behaviors and maladaptive interpersonal relationships. Likewise, only two of the 11 participants reported impulsivity of sex offenders as more challenging to treat over maladaptive relationships and antisocial behaviors.

In RQ3, I examined how participants discussed antisocial behaviors when providing therapy to sex offenders. Out of 11 participants, seven reported observing a lack of social responsibility (Item 5), and all 11 participants reported observing difficulty with social situations (Item 6). Ten of the participants reported observing a lack of empathy when providing therapy to sex offenders (Item 7). When I asked about the prevalence of antisocial behavior relative to maladaptive interpersonal relationships and impulsivity, one reported having observed antisocial behaviors as more prevalent. In Item 9, I asked participants which of the three behaviors (maladaptive interpersonal relationships, impulsivity, or antisocial behaviors) is most challenging to treat, and five of the 11 participants reported that antisocial behaviors is the most challenging.

In RQ4, I examined what, if any, additional behaviors, other than maladaptive interpersonal relationship issues, impulsivity, and antisocial behaviors, participants discussed and/or observed when providing therapy to sex offenders (Item 10). Out of 11 participants, nine provided a response to Item 10, indicating that they had observed behaviors other than maladaptive interpersonal relationship issues, impulse control, and antisocial behaviors, when providing therapy to sex offenders. Such behaviors were poor

coping strategies, trust issues, sociopathic behaviors, emotional immaturity, anger, victim mentality, etc. (see Table 2). In Item 11, I asked if participants had any additional comments that they would like to provide that they felt was relevant for the direction of the study. Out of 11 participants, seven participants responded to Item 11. Some comments included having experienced clients who presented with poor coping strategies, trust issues, sociopathic behaviors, emotional immaturity, chemical imbalance, history of abuse, self-esteem issues, feeling isolated, anger, victim mentality, and depression/anxiety. I listed these data in Table 2 which was further analyzed in Chapter 5.

In Chapter 5, I provided further summary and interpretation of the data analysis for each of the 11 interview items. In the chapter, I discussed how the results were compared to what I found in the related peer-reviewed literature which I also described in Chapter 2. I provided further discussion on the assumptions and limitations of the study, and recommendations for further research. Additionally, I assessed in Chapter 5 the implications of the present findings for positive social change.

Chapter 5: Discussion

Purpose

The purpose of this research was to examine reported experiences of mental health professionals regarding the assessment and treatment of maladaptive interpersonal behaviors, impulsive lifestyle, antisocial personality behaviors, and perceived commonality among these factors in known sex offenders. In this chapter, I present the findings based on the data I gathered through interviews. In this research, I examined the experiences of mental health professionals who provide treatment to sex offenders. Specifically, this research examined whether or not participants reported a commonality when providing treatment in observed and reported difficulties with relationships, impulsivity, and antisocial behaviors.

In this chapter, I further analyzed the findings shown in Chapter 4 for each of the 11 items of the interview and further described them in terms of the research questions. In this chapter, I discussed the interpretation of findings and how I compared the data to what was found in peer-reviewed literature, as described in Chapter 2. In Chapter 5, I also discussed the limitations of the study and recommendations for further research. Additionally, I reviewed the implications and impact for positive social change in Chapter 5.

I derived the results of this study from participant interviews and reviewed previous research in the area of detecting and describing behavioral patterns among sex offenders. Hare (1991) considered the PCL-R to be a viable assessment tool for detecting characteristics among sex offenders that helps in determining the likelihood of recidivism. In this research, I accounted for the sensitivity to behaviors that Polaschek

(2003) and Berlin (2003) considered to be significant markers such as high impulsivity, interpersonal relationship issues, and antisocial behaviors. By looking at these behaviors, which aligned with Ellis' (1991) synthesized theory of rape that posits strong-rooted biological and sociological underpinnings, I examined in this research maladaptive interpersonal relationship issues, impulsive behaviors, and antisocial behaviors. Additionally, I examined these behaviors by using the Interpersonal Closeness Measure (Berger et al., 2016), Impulsivity Measure (Chan et al., 2015), and Disturbing Behaviors Checklist II (Algozzine, 2011).

Interpretation of Findings

Harris, Boccaccini, and Rice (2017) suggested that specific factors exist within the population of sex offenders that would reflect strong indicators of recidivism. Harris et al. (2017) showed that individuals high in psychopathy failed to form stable relationships and tended to exhibit traits of antisocial behaviors, as measured by the PCL-R. Krueger et al. (2002) examined individuals who exhibited desires to disinhibit themselves in the interests of self-gratification, usually through substance use. Their research lended to the framework of Ellis' (1991) theory of rape and linked such behaviors to an individual's impulsivity.

The 11 participants who participated in this study consented to recorded phone calls and agreed that they met the eligibility requirements to participate in this study. I transcribed all 11 interviews and coded them to determine if participants reported each of the particular behaviors discussed during the interviews. Additionally, I invited participants to openly discuss other behaviors associated with sex offenders, as they had observed them or their clients had self-reported behaviors. I used open-ended questions

(Appendix A) based on items from the following psychometric measures, respectively: the Interpersonal Closeness Measure (Berger, Heinrichs, von Dawans, Way, & Chen 2016), the Impulsivity Measure (Chan, Lo, Zhong, & Chui, 2015), and the Disturbing Behaviors Checklist II (Algozzine, 2011).

The research questions are answered according to what was collected, coded, and listed in Chapter 4, Figure 1:

RQ1: How do mental health professionals observe maladaptive interpersonal behaviors in individuals who are known sex offenders?

Using this question, I examined how mental health providers describe their clients' difficulty in maintaining and establishing close relationships with other people. I related Items 1 and 2 to maladaptive interpersonal behaviors. Ten participants reported Item 1 and discussed their clients having issues with maladaptive interpersonal relationships and Item 2 received eight positive reports of participants discussing clients' having issues with caring about others. When asked which of the three behaviors is most common in sex offenders, five out of 11 participants positively reported in Item #8, indicating that maladaptive interpersonal relationship issues are more commonly encountered during treatment than impulsive behaviors or antisocial behaviors.

Blaske, Borduin, Henggeler, and Mann (1989) examined interpersonal relationships among 60 male adolescents and found that sex offenders presented with neurotic symptoms and difficulties among their peers when compared to the non-offending population. Lawing, Frick, and Cruise (2010) further examined 150 adolescents who were detained for having committed a sexual offense. Through extensive assessment and self-report interviews, they found that sex offenders, especially those who

commit violent offenses, presented with callousness and unemotional traits, along with impulsive and antisocial behaviors. As Ellis (1991) originally suggested, such traits are frequently a factor coinciding with an inhibited ability to form healthy relationships.

Participants in this study strengthened existing theories of maladaptive interpersonal relationship behaviors by describing how the individuals whom they treat as sex offenders present with similar difficulties. There was also a common thread through the interviews that suggested that sex offenders are further isolated by the conviction record itself, suggesting potential difficulties forming attachments to others. Two of the participants implicated isolation as a factor that contributes to recidivism. The findings of the present study support Ellis' (1991) theories and suggests that maladaptive interpersonal relationships are relatively common among sex offenders.

RQ2: How do mental health professionals observe impulsiveness in individuals who are known sex offenders?

In this question, I examined how mental health providers describe their clients' difficulty managing impulsivity. In Items 3 and 4, I asked questions related to impulsivity in their behaviors. In Item 3, 11 participants reported a lack of controlling impulses and In Item 4, 10 participants reported a lack of resisting temptations. When I asked which of the three behaviors is most common in sex offenders, two out of 11 participants positively reported Item 8, indicating that participants encountered impulsivity issues and they are more commonly encountered during treatment than maladaptive interpersonal relationships or antisocial behaviors by those who participated in this research.

Murrie et al. (2012) used the PCL-R assessment to correlate factors that contributed to recidivism and violent behaviors toward others. They found that Factor 2

of the assessment, which measures impulsive lifestyle facets, is a strong predictor of sexual offense and reoffending. As with maladaptive interpersonal relationship issues, Lawing et al. (2010) also implicated impulsivity issues as a common trait among the sex offender population. In these findings and the findings of the present study, I showed that sex offenders exhibit less restraint and serve more immediate gratifications without considering consequences. These are factors that mental health providers who treat sex offenders should consider when determining risk of committing sexual offenses.

In the present findings, I showed that impulsivity is relatively common among sex offenders, but less common and less challenging to treat, when compared to interpersonal relationships and antisocial personality behaviors. One participant reported to the item that asks which trait is more challenging, that impulsivity is a behavioral trait that can be managed. Five participants reported that personality traits tend to be more challenging when treating sex offenders.

RQ3: How do mental health professionals observe antisocial personality behaviors in individuals who are known sex offenders?

In this question, I examined how mental health providers describe their clients having demonstrated antisocial behaviors. In Items 5–7, I asked questions related to antisocial behaviors. Seven participants reported Item 5, which I asked about lack of social responsibility, and 11 participants reported Item 6 discussing difficulty with social situations. Ten participants reported Item 7 and discussed a lack of empathy presented by sex offenders. When I asked which of the three behaviors is most common in sex offenders, one out of 11 participants positively reported that antisocial behaviors are most common in Item #8. In Item 9, I asked participants which behavior is the most

challenging, and five out of 11 positively reported that they consider antisocial personality behaviors to the be the most challenging of the three when treating sex offenders.

Examining MMPI-2 results of offenders, Erickson et al. (1987) found indications of predictive validity in personality profiles as to whether or not an offender was likely to offend or reoffend. Specifically, those individuals with 4–9/9–4 or psychopathic deviate and hypomania, profiles suggested a profile normally associated with antisocial personality disorder (Erickson et al., 1987). Lawing et al. (2010) further stated antisocial behaviors associated with impulsivity and callousness tend to be a strong trait presented by individuals who are treated for sexual offenses.

Based on the participants' responses in the present study, I found that antisocial behaviors are relatively common among sex offenders, but less common and more challenging to treat, compared to interpersonal relationships and impulsivity behaviors. The research participants who positively reported that antisocial personality behaviors are more challenging made statements indicating that personality is not a behavior. Thus, it's more difficult to treat among sex offenders.

RQ4: How do mental health professionals see commonality among these behaviors in individuals who are known sex offenders?

In Item 8, I examined commonality and prevalence of maladaptive interpersonal relationships, impulsivity, and antisocial behaviors as reported by participants. Out of the 11 participants, five positively reported maladaptive interpersonal behaviors as the most common, while impulsivity (two out of 11) and antisocial behaviors (one out of 11) as most commonly encountered during treatment of sex offenders. Three out of the 11

participants did not answer definitively or chose not to answer Item #8. Item #9 examined the most challenging behavior to treat of the three. Five of 11 participants reported antisocial behaviors as the most challenging to treat. Maladaptive interpersonal behaviors (three out of 11 participants) and impulsivity (two out of 11 participants) were described as least challenging to treat among the three behaviors examined in this research.

The importance of understanding behavioral versus personality traits is paramount in this study. As participants of this study acknowledged that impulsive behaviors can be treated through cognitive means and learning models, which aligned with what Ellis (1991); Bonta, Law, & Hanson (1998); and Polaschek (2003) suggested through their research, personality factors may be more problematic, as they likely resulted from various childhood trauma or negative perceptions of life events. The National Sexual Violence Resource Center (2015) reported a correlation between victims of abuse developing lifelong psychological disorders and maladaptive personality traits. Boccaccini et al. (2013) examined the results of 76 sex offenders using the Personality Assessment Inventory (PAI). In their findings, they linked borderline personality disorder to potential commission of sexual offenses (Boccaccini et al., 2013). Additionally, they found that antisocial orientation was a strong predictor of treatment attrition, which five of the 11 participants in the present study observed and confirmed as a challenge to treatment for sex offenses.

For this study, I afforded participants the opportunity to discuss supplemental behaviors that observed through Items 11 and 12. Some of the behaviors that the participants described included presenting with poor coping strategies, trust issues, sociopathic behaviors, emotional immaturity, history of abuse, self-esteem issues, feeling

isolated, anger outburst, victim mentality, and depression and anxiety issues. Although I discussed these behaviors in this study, they were not included in the results, as it was outside the scope of this research. I listed those behaviors in Chapter 4, Table 2, which benefited consideration for future research opportunities.

Limitations of the Study

In this research, I used a phenomenological qualitative design to examine reported experiences of mental health professionals regarding the assessment and treatment of maladaptive interpersonal behaviors, impulsive lifestyle, antisocial personality behaviors, and perceived commonality of these factors among sex offenders. I selected the sample of practitioners from the northeastern United States which provided a limited representation of those who treat sex offenders within the United States. Those who were incarcerated for sexual crimes were convicted based on state and federal laws, which is representative of the population that practitioners, similar to the ones who participated in this study, would normally treat across the United States.

Another limitation of this research was the inclusion of sex offenders who were convicted of pedophilia. While some sex offenders who were considered pedophiles have committed acts of sexual assault, many sex offenders were charged with possession of illicit material and have not assaulted another person (Seto et al., 2006). These individuals have been charged and convicted as sex offenders without necessarily having committed any physical abuse or sexual assault (Seto et al., 2006). The term pedophile includes individuals who were convicted of producing, trafficking, or possessing pornography containing children (Seto et al., 2006). Local and state laws vary from state to state as to what constitutes illicit photography, so accurately defining what is illicit and

what's not presents some challenges. The primary reason for including pedophiles is based in the theory that there is a correlation between pornography and sex offenses (Linz, Donnerstein, & Penrod, 1988). Such theories also contributed to the discussion of issues with managing impulsivity and self-gratifcation, which I also examined in this research.

I used open-ended questions in order to elicit unedited and unformatted commonalities in the participants' responses to the interview questions. While I chose a qualitative design for this research, there are some limitations to qualitative over quantitative designs. As Atieno (2009) described, subjectivity may lead to procedural problems, due to participants being permitted to respond to each question without any limits to words, time, or tone. The interview items were formatted and there was a prescribed flow to the interview, but the participants were not bound by any procedure or guidance in how she or he responded. Another limitation that I suggested was difficulty in replicating this research due to variability in participants' exact responses. With qualitative research, I agree it would be difficult to get the exact same or similar responses from other participants, as Atieno (2009) also suggested. In this study, I examined the qualitative data in the form of unedited and unprompted responses from 11 mental health professionals. As such, it was also important to note limited external validity with a qualitative design as the sample size is significantly smaller in size, compared to a quantitative design. Using the number of participants in the present study, I provided a snapshot of the population in order to assist with future directions of quantitative research.

In her research, Nelson (2002) suggested that mental health providers who treat sex offenders should participate in a self-evaluation to assess their fitness, openness, and personal biases relating to sex offenders in treatment. It was important to ensure that the treatment provider believed that treatment is the most appropriate solution and their clients' best interests were being accounted for. Nelson (2002) posited that professionals who have vast clinical training and experience help to mitigate occurrences of bias and prejudice among mental health treatment providers who treat sex offenders. This would include extensive clinical experience, a solid foundation of psychological development, knowledge of effective assessment tools, and a firm grasp on theoretical models and treatment modalities (Nelson, 2002). For this research, I asked the participants to disclose their experience working with the sex offender population and their credentials, licenses, and certifications. All participants held state licenses and all of them held at least one certification from a state licensing body to specialize in sex offender treatment and counseling. Thus, I concluded that all participants were experienced professionals who worked with sex offenders, which minimized the risk to biases being introduced in this research.

Recommendations

For this research, I laid the foundation for a better understanding of where current evaluations failed to detect behavioral traits of sex offenders that could lead to recidivism. Evaluators currently use many psychological and neurological instruments in an attempt to predict the likelihood of recidivism. Erickson et al's. (1987) research was instrumental in using the MMPI-2 in detecting personality traits of incarcerated offenders to determine which profiles have a greater tendency for recidivism. In their research, they

found that there was a strong correlation between offenders who committed rape of adult women to have a 4–9/9–4 profile, or psychopathic deviate and hypomania, which indicated a relationship between this offense and antisocial personality disorder (Erickson et al., 1987).

Harris et al. (2017) used the PCL-R along with other variables of measurement, such as paraphilia diagnoses to predict the rate of recidivism among 687 offenders released after having been evaluated. As a result of their study, they failed to find any significant correlation, using the PCL-R, between differing levels of diagnoses of paraphilia and other offense characteristics with the rate of recidivism. However, they used PCL-R which was instrumental in identifying areas of marked deficiencies in interpersonal skills, impulsivity, and antisocial behaviors, when examining offenders (Boccaccini et al., 2012). The use of the PCL-R in such a capacity demonstrated, while specialists in the field of psychology who evaluated and treated sex offenders had some evidence of factors and characteristics of individuals who had a history of sexual offenses, there is much work to be done to both better assess for behaviors and traits common to sex offenders and treatment of sex offenders.

Wollert and Cramer (2012) argued that clinical psychologists who used risk assessment systems were doing so with little to no evidence of long-term outcome successes. In their research, they evaluated the efficacy of the constant multiplier assumption and its ability to detect mathematically sound values on offenders at 5 years (P5) and 20 years (P20), with the likelihood to offend after release from incarceration. The authors called for better evaluative tools or improvements, rather than using the

Static-99R and Structured Risk Assessment, to better gauge the level of risk of recidivism among sex offenders.

Lisak and Roth (1990) pointed out the prevalence of detectable sex offenders among normal populations; they estimated that 10% of sex offenders are actually detected, leaving nearly 90% of them unaccounted for. This is likely due to underreporting by victims due to fear of reprisal, further violation, or public humiliation. Furthermore, those who commit sexual offenses are not likely report their offenses for fear of consequences and public humiliation. The problem with this paradigm is neither the victims nor the perpetrators are identified and able to access much needed treatment (McLaughlin, Uggen, & Blackstone, 2017). While data on underreported sexual offenses is plenty yet still very new, mental health professionals who specialize in treating sex offenders attempting to predict and detect offenses and recidivism continues to be a problem on the rise.

Researchers who intend to further studies in evaluating and detecting sex offenders would greatly benefit the field of mental health and society. The data collected from this research is good indicator that mental health professionals who provide treatment to sex offenders have various methods of treating them (Polaschek, 2003). Kirsch and Becker (2006) reported that there were eight mainstream treatment modalities: insight oriented, classical behavioral, faith-based treatment, cognitive-behavioral methods, hormonal medication, therapeutic communities, medical castration, and intensive supervision. Despite differences in the eight treatment modalities, participants in this study reported similarities in issues that arise during treatment, such as commonality with maladaptive interpersonal relationship, impulsive behaviors, and

antisocial behaviors. All 11 participants reported that those three traits were presented by their clients at varying levels; in addition to their clients having identified other psychological issues and experiences of their clients, such has a history of abuse, isolation factors, and trust issues. Those aiming to conduct future research examining the relationship between these additional factors and the tendency to commit sexual offenses may help the development of methods to facilitate early detection and intervention of would-be sex offenders and those with increased risk for recidivism.

Implications

Through this present study, I demonstrated the potential to impact positive social change among several areas of research and practice. Using a narrative interview with open-ended questions, I provided a good amount of data that could be used to guide further research and gain more insight into what mental health professionals who treat sex offenders are experiencing during treatment sessions. All 11 of the participants discussed how their clients experienced difficulties with controlling their impulses, given different environmental factors, such as proximity to potential victims and exposure to triggers that could cause relapse.

In this research, I found that, while participants mostly agreed that relationship issues and impulsivity were most prevalent among sex offenders, participants reported antisocial behaviors as the most challenging behaviors to treat. One participant reported addressing this challenge via a treatment model for sex offenders that doesn't address personality disorders, and instead focuses on the cognitive aspects of sex addiction. If addiction models that are aimed at treating cognitive-behavioral issues, when indeed there may be personality disorders that are overshadowing them, current treatment

models may appear to be ineffective in treating sex offenders and reducing recidivism. Thus, researchers who using the data from this present study could usher in the development or modification of treatment models for sex offenders.

Owing to the limited geographical representation in the present study, researchers could select participants with a similar procedure in different geographical locations or even broadened to more accurately capture the professional experiences of treatment providers in a much larger national footprint. The impact of researchers adopting this style of research could lead to more narrowly focused evaluation tools and treatment models that more accurately address factors related to sex offenders other than those addressed in current addiction models.

Summary

In this chapter, I analyzed the narrative data collected from each of the 11 items provided by 11 participants who treat sex offenders. Using the four research questions, I aimed to find how mental health professionals observe maladaptive interpersonal behaviors, impulsive behaviors, antisocial behaviors, and commonality among sex offenders with respect to those three traits. Using the results of the analysis, I concluded that the majority of participants were able to confirm the presentation of each trait and discussed at some level-how their clients presented with those traits.

In addition to discussing maladaptive interpersonal relationship issues, impulsive behaviors, and antisocial behaviors, most of the participants discussed a higher prevalence of interpersonal relationship issues and impulsivity than antisocial behaviors. While the least prevalent of the three behaviors was antisocial behaviors, five of the participants did describe antisocial behaviors as the most challenging of the three. Other

themes that were noted during the narrative interviews were poor coping strategies, trust issues, sociopathic behaviors, emotional immaturity, chemical imbalance, history of abuse, self-esteem issues, feeling isolated, anger, victim mentality, and depression and anxiety.

Based on the data from this research, I recommend further research to be conducted in order to better quantify the degree to which maladaptive interpersonal relationships, impulsive behaviors, and antisocial behaviors are measured among the population of sex offenders. Researchers pursuing such efforts could have a positive social impact on the way mental health professionals identify risk of recidivism and provide better, more accurate treatment models when treating sex offender clients. Considering the implications of this research, my goal was to not only to identify potential alternative factors that affect treatment of sex offenders, but to use this research's procedure and method could be modeled to be used in different geographical areas or expanded to include other traits and behaviors.

Conclusion

Through this research, I intended to examine experiences of mental health professionals regarding the assessment and treatment of maladaptive interpersonal behaviors, impulsive lifestyle, antisocial personality behaviors, and perceived commonality among these factors in known sex offenders. Current therapeutic treatment methods and assessment tools have been ineffective in identifying at-risk offenders and reducing recidivism of sex offenders (Furby et al., 1989). Researchers and mental health treatment providers who used current models of treatment, focused on the reduction of addictive behaviors using treatment models for substance abuse (Polaschek, 2003;

Krueger et al., 2002). Ellis' (1991), through his synthesized theory of rape, offered alternative explanations beyond addiction and cognitive behavioral models, taking into account biological, genetic, and sociological factors. Based on past research of cognitive-behavioral models, neuropsychological models, and antisocial personality models, I selected three behaviors for this research: maladaptive interpersonal relationship issues, impulsive behaviors, and antisocial behaviors.

Within the research methodology, I used 11 open-ended questions to interview 11 participants. Using the narrative responses of the participants, not only did I confirm the presence of maladaptive interpersonal relationship issues, impulsive behaviors, and antisocial behaviors, but a majority of the participants also indicated maladaptive interpersonal relationship issues and impulsive behaviors were more prevalent than antisocial behaviors. However, five of the 11 participants reported antisocial behaviors as being more challenging to treat than maladaptive interpersonal relationship issues or impulsive behaviors. While for this research, I did not quantify the degree to which mental health professionals observed these behaviors, nor their intensities, I offered a springboard for further discussions and research.

In addition to examining maladaptive interpersonal relationship issues, impulsive behaviors, and antisocial behaviors, I used open-ended questions which allowed participants some latitude to discuss other issues that their clients presented with during treatment. Therefore, I aimed this research to steer future studies in examining those other issues and further impact positive social change. Additionally, researchers could replicate this research process to guide future studies on a more narrowly focused geographical area or broadly focused on a regional or national level. How I conducted

this research could impact the development or improvement of assessment tools and assist specialists within the forensic psychological and mental health communities with providing more effective treatment modalities for sex offenders.

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Appendix A: Research Recruitment Letter

Psychological Characteristics of Sex Offenders

Seeking qualified counselors, therapists, and mental health professionals who specialize in the treatment of sex offenders.

This study is being conducted by: Patrick McMunn, PhD Clinical Psychology student at Walden University.

Background Information:

The purpose of this study is to collect narratives of counselors, therapists, and mental health professions who specialize in the treatment of convicted sex offenders and expand this knowledge into themes of specific problems, treatments, detection, and rehabilitation.

Procedures:

If you agree to be in this study, you will be asked to answer questions presented by the researcher (approximately 30 minutes) telephonically or face-to-face. The interviews will be audio recorded. Consent forms must be signed in order for the research to be conducted.

For this study, I am seeking counselors, therapists, and mental health providers who specialize in the treatment of sex offenders and meet the following criteria:

1. Licensed psychologist, counselor, or therapist
2. Two or more years practicing in treatment of sex offenders
3. Treated 10 or more sex offenders
4. Fluent in English language

If you meet the above criteria and would like to participate in this study, please return the consent form in the addressed, stamped envelope, or email (patrick.mcmunn@waldenu.edu). After I receive your reply, I will contact you to arrange a date and time for our interview. If you do not wish to participate, no one will contact you, and your anonymity will remain protected.

PLEASE RETURN ALL MATERIALS TO THE FOLLOWING ADDRESS:

Thank you for considering participation in this study.

Appendix C: Initial Questionnaire

Directions:

Please complete the questionnaire below to the best of your ability. This questionnaire is confidential and all efforts will be made to protect all information relating to the responses you provide.

Participant #_____

1. What is your age in years?
   a. 29 and younger
   b. 30 to 55
   c. 56 and older

2. What is your race?
   a. White
   b. Latin
   c. Black
   d. Asian
   e. Native American
   f. Alaskan Native
   g. Other (Please list)

   _____

3. How many years experience do you have treating sex offenders?
   a. None
   b. 0-1 years
   c. 2-5 years
   d. 6-10 years
   f. 11+ years

4. How many clients would you estimate that you have treated for sexual offenses?
   a. None
   b. 0-10
   c. 11-50
   d. 51-100
   e. More than 100

5. Have you received specialized training in treating sex offenders?
   a. Yes
   b. No

6. What is your highest level of education?
   a. Bachelors degree
   b. Masters degree
   c. Doctorate degree

7. What licenses, if any, do you currently hold?
   a. LPC
   b. LMFT
   c. SAAC
   d. LC
   e. Other (please specify) _____

Appendix D: Interview Questions

1. How close have you observed or had clients who are treated for sexual offense self-report difficulties with maintaining close relationships with others?

2. How have you observed or had clients who are treated for sexual offense self-report difficulties with caring about others?

3. How have you observed or had clients who are treated for sexual offense self-report difficulties with controlling their impulses?

4. How have you observed or had clients who are treated for sexual offense self-report difficulties with resisting temptations?

5. How have you observed or had clients who are treated for sexual offense self-report difficulties with being able to assume social responsibility?

6. How have you observed or had clients who are treated for sexual offense self-report difficulties with social situations, involving verbal communication with others?

7. How have you observed or had clients who are treated for sexual offense self-report difficulties showing empathy?

8. What would you consider the most prevalent and commonly observed trait in your treatment of sex offenders in terms of difficulties with maintaining relationships, impulse control, and antisocial personality behaviors?

9. Which those behaviors do you find to be the most challenging when treating individuals who have committed sexual offenses?

10. Are there any additional behaviors or difficulties, other than issues with maladaptive inter-relationship issues, impulse control, and antisocial behaviors, that you have observed to be relatively common among sex offenders?

11. Is there anything you would like to ask or any additional comments you would like to provide that you feel is relevant for the direction of this study?

Appendix E: Test Use Permissions

Interpersonal Closeness Measure

Version Attached: Full Test

PsycTESTS Citation:
Berger, J., Heinrichs, M., von Dawans, B., Way, B. M., & Chen, F. S. (2016). Interpersonal Closeness Measure [Database record]. Retrieved from PsycTESTS. doi: http://dx.doi.org/10.1037/t47962-000

Instrument Type: Rating Scale

Test Format:
The Interpersonal Closeness Measure contains 6 items rated on a 9-point Likert-type scale.

Source:
Berger, Justus, Heinrichs, Markus, von Dawans, Bernadette, Way, Baldwin M., & Chen, Frances S. (2016). Cortisol modulates men's affiliative responses to acute social stress. Psychoneuroendocrinology, Vol 63, 1-9. doi: 10.1016/j.psyneuen.2015.09.004, © 2016 by Elsevier. Reproduced by Permission of Elsevier.

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PsycTESTSTM is a database of the American Psychological Association

doi: http://dx.doi.org/10.1037/t47962-000

Interpersonal Closeness Measure

Items

1. How close do you feel to your conversation partner?
2. How similar are you to your conversation partner?
3. How much do you like your conversation partner?

4. To what degree could you imagine becoming friends with your conversation partner in the

   future?
5. Compared to all your other relationships, how close would you describe the relationship with

   your conversation partner to be?
6. Compared to relationships other people have, how close would you describe the relationship

   with your conversation partner to be?

Note. Items were rated on a 9-point Likert-type scale.

RATE Scales

Version Attached: Full Test

PsycTESTS Citation:
Young, S. (2007). RATE Scales [Database record]. Retrieved from PsycTESTS. doi: http://dx.doi.org/10.1037/t26807-000

Instrument Type:
Inventory/Questionnaire

Test Format:
Responses for the 32 items range from "not at all" to "most of the time" on an 8-point Likert scale.

Source:
Supplied by Author.

Original Publication:
Young, S., J., & Ross, R. R. (2007). R&R2 for ADHD Youths and Adults: A Prosocial Competence Training Program.
Ottawa: Cognitive Centre of Canada.

Impulsivity Measure

Version Attached: Full Test

Note: Test name created by PsycTESTS

PsycTESTS Citation:
Chan, H. C., Lo, T. W., Zhong, L. Y., & Chui, W. H. (2015). Impulsivity Measure [Database record]. Retrieved from PsycTESTS. doi: http://dx.doi.org/10.1037/t39395-000

Instrument Type:
Rating Scale

Test Format:
Responses for the 2 items range from 1 (strongly disagree) to 4 (strongly agree) on a 4-point Likert scale.

Source:
Chan, Heng Choon (Oliver), Lo, T. Wing, Zhong, Lena Y., & Chui, Wing Hong. (2015). Criminal recidivism of incarcerated male nonviolent offenders in Hong Kong. International Journal of Offender Therapy and Comparative Criminology, Vol 59(2), 121-142. doi: 10.1177/0306624X13502965.

doi: http://dx.doi.org/10.1037/t39395-000

Impulsivity Measure
Items
I cannot control my impulses.
I cannot resist temptations.
Note . Responses are on a 4-point Likert scale from 1 (*strongly disagree*) to 4 (*strongly agree*).